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ABSTRACT

Three empirical research-based chapters comprise this monograph. Each chapter attempts to analyze the problem addressed in such a manner that readers themselves may be induced to innovate solutions. The thrust of the monograph is to engage its audience in a collective positive spirit of innovation for the benefit of institutions that wish to better serve their clientele. The first chapter is an overview of existing health care delivery systems available to the Spanish speaking/surnamed population. Suggestions for innovations are at the level of organizational modifications for community mental health centers. The second chapter deals specifically with the instrumentation of personality assessment and the interpretation of its results. Suggestions for different ways of interpreting results when dealing with the target populations are made. Some directions for the development of more relevant tests are also suggested. The third chapter is concerned with the development of professional personnel and describes an empirical experiment on the ethnic characteristics of the therapists and the impact that such ethnic cues might have on their patients. Suggestions are made as to how best to proceed in the therapeutic relationship between patient and therapist. (Author/AM)

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DELIVERY OF SERVICES FOR LATINO COMMUNITY MENTAL HEALTH

edited by

Rodolfo Alvarez

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PREFACE

In recent years it has become increasingly and painfully apparent that the hispanic community has a minimal relationship with the health services establishment of the country. In particular, the mental health services network of organizations such as mental hospitals, community mental health centers, as well as their attendant professional personnel such as social workers, clinical psychologists, medical doctors, and others have virtually no experience or even contact with the vast majority of the Spanish speaking population that is manifestly in need of these services.

Scholars and militant advocates may disagree among and between themselves as to the antecedent determinants of the condition of neglect in which the Spanish speaking population currently finds itself. Similarly, there is some value in detailed analyses of what is defective in the system of service delivery to this target population. However, it is clear that what is urgently needed is the proposition and promotion of innovations designed to ameliorate the existing situation. Having recognized and analyzed the problems, the key to their solution is contained in what is done from this point forward. Innovations created in one setting need to be communicated to other organizations with the anticipation that the process of implementation in a different environment will itself produce new insights and service innovations. In this regard, the policy of the Spanish Speaking Mental Health Research and Development Program is consistent with the basic tenents of the community mental health movement.

While there is no exact and technically precise definition of what is still an evolving concept of "community mental health," it can be differentiated from the traditional, exclusively medical approach to mental health by four of its major characteristics. *First,* the community mental health movement seeks an empirical, research-based understanding of the interconnectedness between family, community, social, economic, and cultural structures, as well as biological and psychic structures, as sources of pressures that directly affect the mental health of individuals. *Second,* the community mental health movement seeks to promote an improved general state of mental health through intervention techniques in which the recipients of health care have had a measure of knowledge of, and participation in, the processes of development and implementation. *Third,* the prime objective is positive and preventive, in that it seeks to promote and maintain health rather than to possess an exclusive concern with the treatment of illness that

has already become too great to be ignored. *Fourth*, the target of the community mental health movement is the entire population of a defined community and not simply those individuals whose mental condition has become so acute as to be identified as mentally ill. In this volume we attempt to apply these concerns to the Latino community of the United States (Chicano, Puerto Rican, and other U.S. ethnic populations of Indian, Spanish, and Latin American heritage) with the explicit objective of making recommendations that may be implemented into public policy.

The present volume contains three empirical research-based chapters that go beyond a mere description of the problems addressed. Each of these chapters attempts to analyze the problem addressed in such a manner that readers themselves may be induced to innovate solutions. Of course, the authors also attempt to suggest innovations. However, the thrust of this monograph is to engage its audience in a collective positive spirit of innovation for the benefit of institutions that wish to better serve their clientele.

The first chapter attempts an overview of existing health care delivery systems available to the Spanish speaking/surnamed population. Suggestions for innovation are fundamentally at the level of organizational modifications for community mental health centers. The second chapter deals very specifically with the instrumentation of personality assessment and the interpretation of its results. Suggestions for different ways of interpreting results when dealing with the target population are made. Some directions for the development of more relevant tests are also suggested. The third chapter is concerned with the development of professional personnel; it describes an empirical experiment on the ethnic characteristics of the therapists and the impact that such ethnic cues might have on their patients. Suggestions are made as to how best to proceed in the therapeutic relationship between patient and therapist.

In assimilating the evidence and intellectual perspectives contained in the present volume, the reader is cautioned to keep in mind the tremendous heterogeneity within each of the subpopulations that comprise the Latino community. Moreover, there are different values and behavioral practices associated with geographical regions as well as economic class differences. Thus, the present volume should be read by participants in the mental health establishment (administrators, psychiatrists, clinical psychologists, social workers, paraprofessionals, health consumer advocates, etc.) with an eye toward the stimulation of their own ideas for the development of better services to the Latino

community. At this point it is safe to say that there are no correct answers, there are only more or less creative, more or less well-intentioned, and more or less empirically research-based innovations of organizational structure, personnel capacities, and utilization of appropriate instruments.

Special thanks are due to Lucile Sangouard and Claudette Steffens for clerical assistance in the preparation of the manuscript.

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Rodolfo Alvarez, Department of Sociology
University of California, Los Angeles, California 90024

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SECTION I

ORGANIZATIONAL INNOVATIONS

DELIVERY OF COMMUNITY MENTAL HEALTH SERVICES TO THE SPANISH SPEAKING/SURNAMED POPULATION

Amado M. Padilla
Department of Psychology
University of California
Los Angeles, California

Rene A. Ruiz
Department of Psychology
University of Missouri
Kansas City, Missouri

Rodolfo Alvarez
Department of Sociology
University of California
Los Angeles, California

In the United States, the Spanish speaking/surnamed (SSS) population receives mental health care of a different kind, of lower quality, and in lesser proportions than that of any other ethnically identifiable population. Demographers consistently agree that ethnic minority group members, and particularly minority group members who are poor, receive less health care than the rest of the population. Studies surveyed confirm the demographic findings; in fact, some indicate that the problem may be more serious in mental health care (see, for example, Abad, Ramos, and Boyce, 1974; Cobb, 1972; Hollingshead and Redlich, 1958; Kolb, Bernard, and Dohrenwend, 1969; Padilla, 1971; Padilla and Ruiz, 1973; and Srole, Langer, Michael, Opler, and Rennie, 1962). The purpose of this article is to delineate why the SSS receive poorer mental health care than other United States citizens and to offer some recommendations for remedying this situation.

It should be clear from the outset that by SSS we are referring to the more than 9 million residents of the United States who have been identified by the U.S. Bureau of the Census (1969, 1971) as people of "Spanish origin." The three largest groups of United States residents

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Labels used by authors to describe which Spanish speaking/surnamed subgroups were studied are retained: e.g., Mexican Americans, Spanish Americans, Hispanos, Puerto Ricans, etc.

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include more than 5 million Mexican Americans, approximately 1.5 million Puerto Ricans, and more than 600,000 Cubans. The remaining 2 million SSS include Central or South Americans and other people of Spanish origin. In all, the SSS represent the second largest minority group in the United States. Further, in spite of geographic and, in some cases, racial differences between the SSS subgroups, all share cultural and socioeconomic similarities which allow us to speak hear with relative ease of the SSS as a homogeneous group.

Utilization of Available Services

A review of the scant literature indicates that the SSS population has been seriously underrepresented among the clientele of existing mental health service facilities. For example, Karno and Edgerton (1969), using California census figures, estimated that Mexican Americans made up 9-10 percent of the state's population in 1962-63; they found that during this same period, the percentages of Mexican Americans receiving treatment in California were as follows: 2.2 percent admissions to the state hospital system, 3.4 percent to state mental hygiene clinics, 0.9 percent to the Neuropsychiatric Institute, and 2.3 percent to state-local facilities. The resident inpatient population was 3.3 percent. Thus, underrepresentation ranges from 6.6 to 9.1 percent. Although these data emanate from one state only, other localities also report high degrees of underrepresentation. For example, Jaco (1960), after surveying the incidence rate of mental disorders during the period 1951-52 in the state of Texas, also reported a lower frequency of utilitization of private and public mental hospitals by Mexican Americans. More recently, Abad and others (1974) have reported that statistics available at the Connecticut Mental Health Center indicate that from July 1, 1971, to March 1, 1972, admissions and readmissions of Puerto Ricans were at least 3.5 times lower than that of blacks, a group comparable in terms of poverty and minority status.

Several investigators have suggested that although the SSS receive comparatively less mental health care than the general population, they actually need more. One reason for this is that the SSS as a group are only partially acculturated and marginally integrated economically and, as a consequence, are subject to a number of "high-stress" indicators. These indicators, known to be correlated with personality disintegration and subsequent need for treatment intervention, include (a) poor communication skills in English; (b) the poverty cycle—limited education, lower income, depressed social status, deteriorated housing, and

minimal political influence; (c) the survival of traits from a rural-agrarian culture which are relatively ineffectual in an urban-technological society; (d) the necessity of seasonal migration (for some); and (e) the very stressful problem of acculturation to a society which appears prejudicial, hostile, and rejecting (see also Abad et al., 1974; Karno, 1966; Karno and Edgarton, 1969; Torrey, 1972). These authors all conclude that demographic data *underestimate* the frequency and severity of mental health problems among the SSS, and that the underutilization of mental health services by the SSS is therefore even greater than we know. The latter conclusion is particularly telling, since a wide range of mental health modalities does not seem as available for the SSS as it does for other U.S. citizens.

Type and Quality of Treatment

If SSS are referred or committed to a mental health service facility for treatment, what type of assistance is extended to SSS clients? In an effort to answer this question, Yamamoto, James, and Palley (1968) report data on the psychiatric care of 594 men and women from four groups: 387 Caucasions, 149 Negroes, 53 Mexican Americans, and 5 Orientals. Each of these persons applied for treatment at the Los Angeles County General Hospital Outpatient Clinic. Yamamoto and his colleagues report that, compared with Anglo controls, SSS patients are referred for individual or group psycho-therapy less often and receive less lengthy and intensive treatment (e.g., terminate sooner or are not recommended for continued sessions). Karno (1966), after reviewing the case records of Negro, Mexican American, and Caucasian patients, confirms Yamamoto and others' findings. Karno states:

> The prospective ethnic patients are less likely to be accepted for treatment than are the nonethnic patients. Ethnic patients who are accepted for treatment receive less and shorter psychotherapy than do nonethnic patients of the same social class characteristics. Ethnicity tends to be avoided by clinic personnel. (P. 520)

In an extensive review of the quality of treatment delivered to ethnic minority group and lower-socioeconomic-status patients, Lorion (1973) states explicitly that "psychiatrists refer to therapy persons most like themselves, that is, whites rather than nonwhites and those in the upper rather than in the lower income range" (p. 266). Lorion states that the proportion of ethnic minority group patients receiving treatment at the Manhattan mental health clinics were in proportion "far below the general population rate for that area." He further maintains

that in the review of a number of studies, "socioeconomic status correlates significantly and negatively with acceptance for and duration of individual psychotherapy, with experience level of assigned therapists, but not with a patient's diagnostic category or source of referral." He states that these findings take on greater significance since the data were drawn from clinics in which ability to pay was not a condition for treatment.

In a related article, Lorion (1974) discusses the expectations of a member of the lower socioeconomic classes toward psychotherapy. Such a person typically hopes for advice rather than reflection and the resolution of "social" rather than "intrapsychic" problems. Thus, if a psychotherapist naively approaches such a patient with an extensive and historical view of childhood, the patient is confused and the therapist frequently experiences frustration when treatment is terminated "prematurely." On the other hand, if the psychotherapist is sophisticated and sensitive enough to recognize that his patient needs to learn the discrimination between personal and social problems, and better ways of responding to both, then treatment has a much greater potential of achieving the success that both patient and therapist are striving toward. This point is supported by Abad and others, who state:

> They (Puerto Ricans) expect to see a doctor who will be active in his relationship with them, giving advice, and prescribing medication or some form of tangible treatment. The more passive psychiatric approach, with reliance on the patient to talk about his problems introspectively and take responsibility for making decisions about them, is not what the Puerto Rican patient expects. This discrepancy between the patient's expectations and his actual experience may well determine whether he continues in treatment. (P. 590)

Thus far we have documented the fact that the SSS underutilize existing mental health services, and, further, that when they do present themselves for service they tend to receive less-frequent care or treatment that is not addressed to their needs or expectations. To understand how these problems have come about, and, more importantly, to develop practical means of circumventing them, it is necessary to turn our attention to several explanations that have been used to account for the lower utilization of mental health facilities by the SSS.

Explanations of Current Practice

Basically, there are one major and two minor formulations to explain why SSS subgroups receive proportionately less mental health

care than does the general population and why, when delivered, such care tends to be less relevant to patient needs and expectations.

Lower Frequency and Severity of Mental Illness

Some evidence exists for the point of view that certain aspects of SSS subcultures protect members against mental breakdown or provide continued familial support after a breakdown (Jaco, 1959, 1960; Madsen, 1964). Jaco, after finding that Mexican Americans are underrepresented in residential-care facilities for the mentally ill, argues that the social structure of Mexican Americans provides protection against stress for its members. Madsen generally concurs with this "stress resistance" formulation, but adds an elaboration of the protective role of the extended family system. He suggests that Mexican Americans discourage the referral of family members to mental health centers—as they would to any other majority group institutional structure—since these are perceived as alien and hostile.

The argument that SSS members are better prepared to tolerate stress or to require less support from social institutions must be interpreted with caution. Both Jaco and Madsen have predicted an increase in emotionally related problems once the SSS undergo a lessening of their traditional social structure (i.e., acculturation). As noted earlier, Karno and Edgerton (1969) and Torrey (1972) identify five sources of massive psychological stress for the SSS which are detrimental to adaptive psychological functioning, with one of these being problems associated with acculturation. Since the literature on the inadequate mental health treatment delivered to the lower socioeconomic classes is essentially corroboratory of these points, it seems reasonable to conclude that the explanation for the underutilization of mental health resources by the SSS poor must be sought elsewhere.

Use of "Folk" Medicine and/or "Faith" Healers

There is a small and steadily growing literature on the use of folk medicine and the practice of faith healing among the SSS (e.g., Creson, McKinley, and Evans, 1969; Edgerton, Karno, and Fernandez, 1970; Garrison, 1971, 1975; Kiev, 1968; Leininger, 1973; and Lubchansky, Ergi, and Stokes, 1970). These investigators either argue or imply that such practices are sometimes selected as alternative solutions for the types of emotional problems for which most majority group members would probably seek more commonplace psychiatric treatment.

One reason why many SSS subgroups may prefer folk healers to more conventional psychiatric treatment may rest in a conceptual

difference between lower-class patients and middle-class therapists as to what constitutes mental health or illness. For example, Hinsie and Campbell (1970, p. 388) define "mental health" or "psychological well-being" as "adequate adjustment, particularly as community-accepted standards of what human relations should be." This emphasis on adjustment implies a distinction between "mental" and "physical" health which does not exist as a concept among SSS subcultures. The state of well-being is usually conveyed in Spanish as *estar saludable* ("to be healthy"), *ser feliz* ("to be happy"), *sentirse o estar como un cañon* ("to feel or be like a cannon"; i.e., the Spanish equivalent of "fit as a fiddle") or *estar sano y fuerte* ("to be healthy and strong"). All of these Spanish idioms imply that physical and psychological "well-being" are inseparable.

These Spanish phrases reflect the cultural truism that some SSS who "do not feel well" (*que no se sienten sanos*) may consult a physician for help but are quite unlikely to approach a mental health professional for help with an "emotional" (i.e., nonphysical) problem. In support of this, Karno and Edgerton (1969) comment on the very active role of the family physician in their study of mental illness among Mexican Americans in Los Angeles. If a problem should be perceived as nonphysical and "spiritual" (for example, guilt, shame, a sense of sin, disrespect for elders or family values), then it seems imminently probable that a religious leader would be consulted for solace. It is equally predictable that fellow members of the extended family system, who share the same cultural values, would probably either recommend or support a referral to a physician or a priest or minister. Thus, problems perceived by the Anglo majority as "emotional" in nature and as requiring psychotherapeutic intervention might be perceived differently by the SSS subculture, for example, as a subtle problem in physical health or one in spiritual malaise.

It should be pointed out that the literature discussing folk psychiatry among Mexican Americans documents the use of such methods among a wide spectrum of the Mexican American population. Creson and others (1969) present data from interviews with twenty-five Mexican Americans receiving treatment in either a pediatric or a psychiatric outpatient clinic. Five subjects admitted having used a faith healer at least once, seven reported that at least one family member had used one, and twenty demonstrated familiarity with the concepts or language of faith healing. These data imply a substantial degree of recourse to faith healers among Mexican Americans, even among patients receiving conventional

medical treatment. A second interpretation is that, among this particular SSS group, these beliefs are highly stable. To quote the authors, "the concept of folk illness was deeply entrenched and resistant to the influence of the Anglo culture and its scientific medicine" (Creson et al., 1969, p. 295). Thus, it may be that recourse to faith healing is frequent enough to inhibit self-referrals to mental health centers.

The article by Leininger (1973) illustrates folk illness in depth, using the case-history approach with Spanish, Mexican American and lower-class Anglo families. In addition to providing a theoretical model to explain why these families embrace the "witchcraft" model of mental illness, the author outlines a series of therapeutic interventions which were effective in reducing personal and familial stress.

In an attempt to answer why the SSS underutilize mental health services, Torrey (1972) observes that Mexican Americans in California's San Jose and Santa Clara counties have "their own system of mental health services." He goes on to describe how this SSS group seeks improved health from self-referral to faith healers. In spite of this community-oriented health system, however, Torrey posits that whenever relevant health services staffed by professionals become available, such services will become the preferred mode of health care sought by Mexican Americans.

In other studies, the Karno-Edgerton researchers recognize the existence of faith healing and describe its practice. However, these investigators point out that use of the system is minimal and that its existence cannot be used to explain the underutilization of conventional health service (see especially Edgerton, Karno, and Fernandez, 1970).

In studies of Puerto Rican spiritualists in New York City, Lubchansky, Erp, and Stokes (1970) and Garrison (1971, 1975) report that although spiritualists are consulted, Puerto Ricans also seek professional mental health services. Thus, among Puerto Ricans who believe in folk medical practices, more conventional mental health services are also sought, when available. For this reason, these authors conclude that the efficacy of professional treatment practices is confounded by the existence of this alternative system of mental health.

In sum, the underutilization of traditional mental health services cannot be explained on the basis that substantial numbers of the SSS are substituting either folk medicine or faith healing. This conclusion seems warranted despite the seemingly valid conclusion by Leininger (1973) that a limited number of rural and/or migrant peoples still adhere to "witchcraft" beliefs.

Discouraging Institutional Policies

There are certain organizational factors and institutional policies which are primarily responsible for the utilization patterns of mental health facilities by the SSS. A review of the literature by Gordon (1965), concerned with characteristics of patients seeking treatment at child-guidance clinics, suggests that the needs of minority group children are not being met (cited by Wolkon et al., 1974). Primary factors responsible for this situation are defined as "inflexible intake procedures and long waiting lists." A study of a specific child-guidance clinic confirmed the inference based on the literature review (Wolkon et al., 1974). The period between the initial self-referral for service and the intake interview ranged from 1 to 52 weeks, with the median 28 weeks. The four Mexican American families seeking treatment had a median wait of 28 weeks with a range of 24.5 to 42.5 weeks. In cases of "emergency," patients were seen "immediately." At the same clinic, while the median waiting period for Caucasians was only 4.5 weeks, the Mexican Americans had to wait 5.5 weeks. Although these differences failed to achieve statistical significance, it is clear that an "emergency" telephone contact is not generally honored for more than a month in the case of Caucasians but takes almost six weeks in the case of Mexican Americans. The inference that delays for ordinary and emergency treatment are discouraging is confirmed by the finding that "77% of the total initial request for services did not receive treatment" (p. 711).

A study even more directly relevant to treatment of the SSS (Torrey, 1972) describes mental health facilities located in a catchment area of 1 million persons, of whom approximately 100,000 are Mexican American. Torrey evaluates these facilities as "irrelevant" for Mexican Americans, since 10 percent of the local population generates only 4 percent of the patient referrals. The basis of his judgment is that the bilingual poor should be expected to generate a larger proportion of referrals because they are subject to many stresses known to bring on mental breakdown. His explanation for this discrepancy is based primarily on the following four variables.

Geographic isolation. Mental health services are "inaccessible" to the SSS because they are often located at the farthest distance possible from the neighborhood of the group with the highest need. All too often, community mental health services are attached to schools of medicine or universities located outside of the *barrio* and accessible only by a half-hour, or so, bus ride. Not only does the distance impede the frequency of self-referrals, but both the cost of transportation and the

lack of adequate child care during the absence of the mother also serve to decrease the utilization of mental health facilities by the SSS.

Language barriers. Torrey describes the "majority" of local Mexican Americans as bilingual and a "significant minority as speaking little or no English." Nevertheless, only 5 members of a professional staff of 120 studied by Torrey spoke any Spanish at all, and none of the directional and/or instructional signs were in Spanish. The interpretation that referrals will decrease if patient and therapist cannot communicate is shared by Edgerton and Karno (1971) and Karno and Edgerton (1969), among others.

Class-Bound Values. Here the reference is primarily to therapist variables, that is, to personal characteristics of the professional staff which dissuade the patient from continued mental health treatment. Abad and others (1974), Yamamoto and others (1968), and Torrey (1972) all indicate that therapists conduct treatment in accord with the value system of the middle class: that is, where the client sees the therapist for fifty minutes once or twice a week or in group therapy, where the client is seen in group once or twice a week. This approach was proven ineffective with and discouraging to lower-class patients. When frustrated because clients fail to respond to this approach, psychologists are more likely not to encourage the SSS client to seek therapy after the first meeting. These points have also been noted by the Karno-Edgerton group as well as by Kline (1969).

Culture-Bound Values. Torrey (1972) attends to therapist variables. His point is that whenever therapists from one culture diagnose and prescribe treatment for patients from another culture, there is an inherent probability of professional misjudgment. To illustrate, he cites data indicating that 90 percent of Anglo residents in psychiatry associate the phrase "hears voices" with the word "crazy," whereas only 16 percent of Mexican American high school students make the same association. The concept of intrinsic culture conflict is also advanced by Bloombaum, Yamamoto, and Evans (1968); the Karno-Edgerton group; Kline (1969); and Phillipus (1971).

Although all four of the factors named above operate to minimize self-referral to mental health centers by the SSS, the last three (language, class, and culture) seem to interact in such a way that the SSS are actively discouraged from utilization of mental health services. A review of studies of low-income patients, both white and nonwhite, who apply for mental health services is particularly relevant here (Lorion, 1973). One major conclusion which emerges from this review is

that middle-class therapists are typically members of a different cultural group than are lower-class patients. As a consequence, patient and therapist experience all the difficulties in communication which occur whenever members of two cultures interact. This "culture conflict" is described in much greater detail in a second paper by the same author (Lorion, 1974). Therapists, and particularly therapists in training, tend to be "turned off" by low-income patients, because they are perceived as hostile, suspicious, using crude language, and expecting *merely* "symptomatic relief." Studies reviewed by Lorion reveal that the success of a therapist in working with low-income patients bears a closer relationship to the therapist's personal characteristics than it does to his experience level or treatment approach. Lorion also reports that therapists from low socioeconomic backgrounds are equally successful with patients from all social classes. The reverse does not seem to be true; that is, that upper-class therapists can deal with equal effectiveness across social classes. More interesting is the fact that "low-income patients engage in significantly more self-exploration early in treatment if matched with their therapist on race and/or socio-economic background" (Lorion, 1974, p. 346). Cobb (1972), in a review of similar literature, supports an earlier argument made in this article that therapeutic expectations vary to some extent as a function of social class. Low-socioeconomic-status patients seem to expect therapists to assume more active roles, as physicians typically do in dealing with medical problems, as opposed to a passive or "talking" role. As a result, Cobb concludes that such patients will probably respond better to therapists who are more active. Taken together, the reviews of Cobb (1972) and Lorion (1973; 1974) lead to two major conclusions: first, race and social class of the therapist seem to effect the patient's response to treatment; and, second, an effective and appropriate "solution" to a problem based upon middle-class values may be totally inappropriate and ineffective for a patient returning to his lower-class environment.

Three Models for Improved Services to the SSS Population

Having reviewed the panorama of complex explanations for the underutilizatoin of mental health services by the SSS population, let us now examine three emerging models for service to this population.

Two points seem relevant here: first, our perusal of the literature suggests that these are the *only* programs designed specifically for the SSS (though there may be others which have not been described in the literature); and, second, these programs seem to have been designed primarily for the treatment of adult self-referrals. We shall return at a

later point in this paper to the need for child-guidance clinics or similar organizations providing treatment programs for younger patients.

Professional Adaptation Model. The major characteristic of this model is that the professional and paraprofessional staff of the community mental health center receive some form of specialized nonstandard training or in some way "adapt" themselves to the specific requirements of serving the SSS population. There are two examples of the professional adaptation model.

First, Karno and Morales (1971) describe the effort in East Los Angeles to design a community mental health service which would attract local Mexican Americans. Major innovations were implemented in staffing, service quarters, and treatment programs. At the end of a two-and-a-half-year recruitment program, the medical director had attracted twenty-two full-time professional, paraprofessional, and clerical personnel. Of these twenty-two, fifteen were "completely fluent" in, four were "conversant" in, and three had a "rudimentary knowledge" of Spanish. Ten were natives and/or residents of the area. More interesting is the fact that twelve were Mexican American and two were of other Latin (Cuban and Peruvian) descent. Service quarters selected are described: "in the heart of the . . . community, convenient for . . . transportation, and comfortable . . . and inviting." The treatment program was based on the philosophy of prevention. Thus, the major thrust was upon mental health consultation to a wide variety of community service agencies. As a back-up, the center offers short-term crisis-oriented treatment using individual, family, group, and chemical therapy. The center seems to be fulfilling the objective of providing appropriate treatment for Mexican Americans because the first two hundred patients matched local population figures.

A second, but somewhat similar, example of the professional adaptation model has been created for the Hispanic population of Denver (Phillipus, 1971). Three of eight team members are Spanish speaking, and the center is located in the neighborhood of the target population, in a building designed so that the prospective patients enter a reception area furnished to resemble a living room. The initial contact person is usually a secretary-receptionist, who is always Spanish speaking. The patient is referred immediately to a team member to begin whatever action seems necessary. The rationale is that treatment is directed toward crisis resolution, which, by definition, is incompatible with rigid adherence to the traditional fifty-minute-hour schedule. The staff began to refer to each other and to the patients on a first-name basis when it became apparent that the use of more formal address was

estranging some members of the Hispanic group. Unequivocal data bearing on the appropriateness of the program for the SSS is difficult to obtain because of its recency. Nevertheless, new referrals increased to a point that proportional representation of the target population relative to the general population was soon reached. When certain specific elements of the program were eliminated, Hispanic self-referrals began to decline but returned to former levels when the elements were reinstated.

Family Adaptation Model. Under the concept that the "family" (i.e., a strong sense of an extended network of primary social relationships) is an important cultural feature that helps provide emotional support against stresses experienced by the SSS population, a variant of group psychotherapy appears to be evolving into what we call the family adaptation model.

Maldonado-Sierra and Trent (1960) describe a "culturally relevant" group psychotherapy program for chronic, regressed, schizophrenic, Puerto Rican males based on assumptions about Puerto Rican family structure. The father of these families is typically described as a "dominant, authoritarian" figure and the mother as submissive, nurturant, and loving. The older male sibling is perceived as a figure whom the other siblings respect, admire, and confide in. In this paper and in a second (Maldonado-Sierra, Trent, and Fernandez-Marina, 1960), the authors describe how these observations were translated into action.

First, three groups of eight patients each spent several weeks together in a variety of activities under the supervision of an individual who represented the older male sibling. A few days before group sessions were initiated, the group was introduced to an older male therapist who represented the father figure. He maintained dignity, remained aloof, and restricted social interaction to brief interchanges. The third therapist was an older female who fulfilled mother-figure expectations by distributing food and chatting informally.

The complexity of the group psychotherapy process of this type is too extensive to describe here. Suffice to state that this analogy of the Puerto Rican family permitted patients an opportunity to identify their common problems and to resolve them therapeutically.

Although this section is thus far limited to the work of Maldonado-Sierra and his associates with hospitalized schizophrenic patients, the family adaptation model deserves further exploration with less severely disturbed SSS patients. The use of cultural themes such as *machismo, respecto, comadrazco-compadrazco,* the role of women, and *personalismo* in therapy, especially family therapy, could prove extremely

valuable in effecting more adequate therapeutic models. Limitations of space preclude a refined definition of these terms, but the basic concepts are that sex roles of SSS men and women are much more rigidly defined; males value highly the virtues of courage and fearlessness (*machismo*); respect toward elders and adherence to cultural norms and values (*respecto*); extended family relations, and especially between godfather-godmother and godchildren are ritualized and have a religious connotation (*comadrazco-compadrazco*); and interpersonal relations are based on trust for people mingled with a distaste for institutions or organizations which operate on a formal and impersonal basis (*personalismo*).

Barrio Service Center Model. By virtue of the conclusion that the vast majority of the sources of stress experienced by the SSS population are of economic origin, the *barrio* service center model is emerging and rapidly gaining legitimacy. This model seems to fit particularly well with the "health services catchment area" concept, where a community center is staffed with personnel that can effectively intervene on behalf of the surrounding population to get jobs, bank loans, and a host of other basic economic services. Four examples of the *barrio* service center model exist in the literature.

First, Lehmann (1970) describes the operation of three storefront neighborhood service centers in New York City over a two-year period. The "typical client (is) a Puerto Rican woman in her mid-30's with two or three children and there is no father present. She is usually an unemployed housewife . . . on welfare . . . with income less than $3000 a year. She is almost certainly born in Puerto Rico . . . and there is only about one chance in three she speaks English well" (p. 1446). Lehmann admits "their record for problem solving was less than brilliant," but attributes whatever successes achieved by the centers to their accessibility, informality, open-door policy with respect to problems and people, and their use of community residents as staff.

A second example of the *barrio* service center model is described by Abad and others (1974) in an article identifying demographic and subcultural characteristics of a Puerto Rican sample of residents of New Haven, Connecticut. The "Spanish clinic," or *la clinica hispana* as it is called by the Spanish speaking community, provides walk-in coverage five days a week and includes psychiatric evaluations and follow-up treatment, medication groups, individual counseling, couple and family therapy, referral services, home visits, and transportation. The staff is bilingual-bicultural and includes a Spanish psychiatrist, a part-time Puerto Rican social worker, and a paraprofessional, indigenous staff

including community leaders with public visibility. The clinic is prepared to intervene in a variety of problem situations, even though they are not of a "clinical" nature. For example, one of the "most frequent roles within the Spanish community is that of intermediary between Spanish speaking clients and other agencies" (p. 592). The article concludes that everyone benefits from such an arrangement: the clientele receives help with problems and this help permits them to function more effectively within their environment, the *barrio* agency gains the reputation of being a "helpful" institution, and community support of the clinic is enhanced.

A third example of the *barrio* service center model is reported by Burruel (1972), who describes the creation of *La Frontera*, a mental health outpatient clinic situated in south Tucson designed specifically to provide care for the Chicano community. Ongoing services of the clinic include "diagnosis and treatment for adults and children with emotional or personality problems and general problems of living" (p. 27). Treatment modalities include "individual therapy, conjoint, family and group therapy" (p. 27). Community representation was originally excluded from planning and administration of the center until "pressure was applied" (p. 29). Currently, the administrative board is a "policy-making board which incorporates representatives from the community." Under the leadership of a Chicano full-time director, deliberate effort was expanded "to make the services relevant to the Chicano community . . . by searching for bilingual and bicultural mental health professionals" (p. 29). A deliberate effort to attract patients from the catchment area was implemented by announcing services on the Mexican radio stations and by eliminating the "waiting list," which is typical of traditional mental health clinics. It is stated that patients may be seen "immediately, hours later, or at the latest, the next day" (p. 32). The response to this innovative program is described as follows: "underutilization of mental health services by Mexican Americans has not been the case at *La Frontera;* 61.5% of the total patient population consists of Mexican Americans" (p. 28).

The fourth and final example of the *barrio* service center model is described by Schensul (1974), who brings the insights of an applied anthropologist to the creation of a new mental health center specifically for an SSS subgroup. Schensul describes how a group of young Chicanos working in Chicago's westside developed the idea in the summer of 1971 to create a community-controlled youth facility to be called *El Centro de la Causa*. The original operating budget of $1800 was raised by a community *fiesta*. According to Schensul, the activist group had within

months convinced a church organization to provide $40,000 for staff and seed money. Within three years, the operating budget was over $400,000. This funding was used to train community residents as paraprofessionals in mental health and to support programs in mental health training, reading improvement, English classes, drug use, recreation, and youth activities. Schensul concludes that whatever success was achieved by *El Centro de la Causa* was due primarily to the enthusiasm of the youthful Chicano activists and their consistent efforts to maintain community involvement.

The major conclusion is that successful therapeutic models for SSS groups are possible when cultural and social variables are made part of the therapeutic setting. It would be misleading to conclude this discussion without noting that some of the successful programs described here no longer exist (e.g., that described by Phillipus). These programs were only highlighted because they represent the very small number that were described in the literature.

General Conclusions and Recommendations

The preceeding review and analysis of the extant literature on the delivery of mental health services to the SSS population clearly reveals a crisis situation. What, then, is to be done? While we are not at this time prepared to generate totally novel institutional mechanisms for the maximum delivery of high-quality mental health services to the SSS population, we are prepared to make a number of recommendations designed to encourage speedier evolution of three promising avenues for improvement of service to this target population. The three models described in the preceding section appear to us to offer considerable promise. Our objective is to focus on their essential distinguishing characteristics and to make compatible recommendations designed to enhance their potential for success.

The recommendations we shall make here may be viewed as stemming from the intellectual perspective of the community mental health movement. Before proceeding to our recommendations, a word is in order about the community mental health movement. While there is no exact and technically precise definition of what is still an evolving concept of "community mental health," it can be differentiated from the traditional, exclusively *medical* approach to mental health by four of its major characteristics. First, the community mental health movement seeks an empirical, research-based understanding of the interconnectedness between the family, community, social, economic, and cultural structures, as well as biological and psychic structures, as

sources of pressures that directly affect the mental health of individuals. Second, the community mental health movement seeks to promote an improved general state of mental health through intervention techniques in which the recipients of health care have had a measure of knowledge of and participation in the process of development and implementation. Third, the prime objective is positive and preventive, in that it seeks to promote and maintain *health* rather than to dwell on an exclusive concern with the treatment of *illness* that has become too great to be ignored. Fourth, the target of the community mental health movement is the entire population of a defined community in its collective sense and not simply those individuals whose mental condition has become so acute as to be identified as mentally ill. These, then, are the four intellectual perspectives guiding our recommendations for the improvement of the three models which appear to be making a beginning toward effective mental health service delivery to the SSS population.

Despite a variety of reasons advanced to explain why the SSS receive proportionately less mental health care, the literature reviewed supports the conclusion that mental health centers across the country are failing to meet the needs of the SSS, with a few notable exceptions. One explanation for this failure is that mental health centers and related agencies are so overly committed to traditional models of health care delivery that they ignore other problems troubling the SSS which are of much greater severity. Centers and agencies offer chemotherapy, occasionally combined with some variation of individual or group counseling, to deal with emotional conflicts of an allegedly intrapsychic nature. These treatment services completely deny, of course, the *bona fide* problems of a "social" nature which are anxiety-provoking, depressing, frustrating, enraging, debilitating, and potentially disruptive to adaptive psychological function. These problems include premature termination of education among the young, elevated rates of arrest and incarceration, more widespread abuse of alcohol and illegal drugs, and higher rates of unemployment—to cite only the most obvious and destructive.

With regard to treatment programs, a number of investigators have commented that many current modalities, especially those based on majority culture and/or middle-class values, have proven ineffective. Encouraging results have been reported, however, from some centers which emphasize some combination of (a) community consultation as a preventative measure, (b) crisis intervention as a matter of course, and (c) "back-up" treatment with individual, group, family, and drop-in

therapies. The literature supports the recommendation that more innovative programs be created and applied on a more widespread basis.

A recommendation for "innovative" treatment programs is self-defeating unless validating research is conducted. Even more critically, demographic and survey research is needed to guide the development of programs with the greatest probability of success. Schensul (1974) speaks of developing "research expertise" among community representatives who lack formal academic, scientific training. Basically, Schensul describes an interaction between community activists and researchers which both educates and enhances the quality of the findings which emerge.

In addition, a wide range of innovative programs are necessary to deal with the social problems besetting the SSS (e.g., remedial education, vocational guidance and retraining, drug-abuse and crime-prevention programs, and possibly even college counseling). The problem of providing appropriate services and attracting clientele can be resolved somewhat by using the agency as a multipurpose center. In addition to providing treatment for a wide range of human problems, the facilities could be used for youth activities (e.g., sports, dances, etc.), for culturally relevant events (e.g., Spanish language films, *fiestas*, etc.), or to satisfy any variety of community needs. It makes imminent sense to involve the community in a center which is situated in their neighborhood to satisfy their needs. The literature supports the contention that the community can be penetrated more effectively, and the quality of services increased, if community representation is involved in the administration. Even more specifically, Burruel (1972) and Schensul (1974) agree that the use of the community mental health center for a variety of purposes has beneficial effects upon attracting more clientele and upon delivering services of higher quality.

We also recommend a "business model" approach in attracting clientele. There may be some value in using advertising media, in both Spanish and English, to disseminate information to the target population concerning available facilities, therapeutic services, and related activities. Boulette (1973), for example, advocates the use of television to inform clientele of the availability of appropriate services. If one is offended by the "unprofessional" aspects of advertising to provide needed services to an oppressed people, one should reflect upon the extensive publicity suggesting examinations for breast cancer that followed the illness and surgery of the wife of an internationally prominent politician.

Only slight modifications in existing treatment methods can be created if one is only marginally aware of the nature of the social problems which plague the SSS. Individual psychotherapy, conducted on a once-a-week basis, and for the purpose of uncovering alleged unconscious conflicts, is obviously highly ineffective with problems of a social nature. To encourage a SSS youngster to remain in school, it makes much more sense to exploit some modification of family counseling techniques. Peer group psychotherapy has achieved some modest success in reducing delinquency rates among the young. Such an approach will probably be highly unsuccessful, however, if the group is conducted by a non-SSS therapist who attempts to encourage introspection based on psychodynamic formulations. Since many members of SSS subgroups conceptualize "treatment" as something they receive while remaining passive, it makes much more sense to encourage discussion groups among potential drug users, possibly including adults who have "kicked the habit." When a patient has the expectation that he will be helped by "doing something," rather than by just talking, it makes sense to involve potential counseling clients in some form of activity therapy (Cobb, 1972). We turn now to recommendations for improvement of each of the three specific community mental health models.

The Professional Adaptation Model. There is the obvious problem of communication. Potential clients whose predominant language is Spanish will certainly feel unwelcome in settings in which they cannot read signs, where they are greeted by clerical personnel to whom they cannot communicate their needs, and where they are subsequently referred to majority group, monolingual, English-speaking professionals. The use of translators is uneconomical, may not communicate nuances successfully, and seems to possess a vast potential to offend and estrange both patient and professional.

Crash programs in Spanish-language acquisition for monolingual, English-speaking professionals are a partial solution to this problem. But language skill is not enough. As we have indicated at several points, the mental health professional must be knowledgeable about the culture of a particular SSS subgroup he works with in order to be effective. Mental health centers may remedy such educational deficits on the part of their professional staff by presenting lectures, seminars, and films on the particular subgroup being treated. In this context, the use of community representatives as teachers and/or consultants who import insight to a particular subculture can be invaluable.

Federal legislation is currently under consideration (S. 3280, Sept. 5, 1974) which bears directly on the resolution of this problem.

Applicants seeking federal funding for programs of health delivery and health revenue-sharing to a catchment area in which "a substantial proportion of the residents of which are of limited English-speaking ability" will be *required* to "(a) make arrangements for providing services to the extent practical in the language and cultural context most appropriate to such individuals and (b) identify as individual on its staff who is bilingual and whose responsibilities shall include providing for training for members of the applicant's staff, and of the staff of any providers of services with whom arrangements are made, regarding the cultural sensitivities related to health of the population served and providing guidance to appropriate staff members and patients in bridging linguistic and cultural differences" (pp. 151-152).*

Every article describing the delivery of mental health services to SSS subgroups agrees on essentially two major points (Abad et al., 1974; Burruel, 1972; Lehmann, 1970; Schensul, 1974). First, it is generally agreed that the problem of poor communication between patient and therapist may be partially resolved by the employment of local community representatives who are bilingual and bicultural, and their subsequent training at the paraprofessional level in the delivery of mental health services. The consequences of hiring and training community residents appear to benefit everyone. The agency achieves a more positive image in the community when local residents are hired; and the quality of services for the SSS is enhanced when patient and therapist can communicate. The second point in which there is consistent agreement is that community involvement in the administration of the mental health center is critical for success. These articles attest that the SSS refuse to refer themselves for treatment to agencies which are perceived as alien institutions intruding into their community and staffed by non-SSS personnel. It is impressive how closely these recommended practices, based upon empirical evidence, matched the letter and spirit of the suggestions which emerged from the recent APA conference held at Vail, Colorado.

The training of paraprofessionals to deliver treatment services and to conduct research leads to an ethical dilemma. Practically, if paraprofessionals are *not* trained, then the SSS will receive essentially no

*Since the writing of the article, S. 3280 was passed by the Senate committee and forwarded to the joint House-Senate conference committee. The bill was passed by the joint conference committee, but pocket vetoed by President Ford at the end of the congressional session in December 1974. Very similar legislation has been reintroduced by both the House and the Senate during the present 94th session of Congress.

services from anyone who shares their bilingual, bicultural background. Whenever paraprofessionals are used for these purposes, however, it is clear that they lack the education, training and experience of the professionally trained members of the helping professions. But as Ruiz (1971) has indicated, no such cadre of SSS professional mental health specialists exists. Thus, unless professional organizations such as the American Psychological Association and the American Psychiatric Association intervene, a significant number of SSS Americans will receive little or no mental health care. We strongly urge the membership of these two organizations to instruct their elected representatives to assume a posture of moral leadership by working to increase the number of students from SSS subgroups in the mental health professions. Organizations which remain passive and apathetic in the face of problems of this nature and severity can no longer describe themselves as created "to promote human welfare."

A cadre of SSS professionals is needed to provide treatment and to conduct research in the mental health area. Without a cadre of such SSS professionals the national problem of underutilization of mental health services by the SSS will probably continue indefinitely. In a recent survey of selected mental health personnel, Ruiz (1971) identified 58 SSS psychologists from a pool of approximately 28,500 and 20 psychiatrists out of 16,000. Despite the tremendous underrepresentation these data denote, the situation is, in fact, even worse: 30 of the 58 psychologists are Spaniards, a group not ordinarily thought of as a disadvantaged minority group.

Regardless of why the SSS are underrepresented in the mental health professions, it is reasonably certain that this situation will remain essentially unchanged without constructive intervention. Recommendations are for programs to identify SSS high school students with academic promise, to encourage continued school attendance, to subsidize educational expenses, and to motivate career choices in mental health fields. Implementation of these recommendations will require funding, legislation, and possibly legal pressure on high school counselors and on admission boards at colleges and universities. But a partial solution could be achieved at minimal expense and without new laws if the membership of the American Psychological Association, as well as the American Psychiatric Association, took a more active role in the training of SSS students in the mental health professions, as suggested above.

Family Adaptation Model. As we noted earlier, there has been little exploration of SSS family roles as a method of therapeutic entry in

working with SSS clients. Such an approach would appear to be successful especially in those situations where several of the family members must be counseled. Therapists knowledgeable of the family dynamics of SSS clients could, for example, use family therapy to better understand the ways in which family members conform to their culturally ascribed roles in times of stress. Moreover, this technique could be used to analyze how the entire kinship network of an SSS person responds as a support system during periods of extreme mental stress. Weaknesses in the kinship support system could be detected and remedied. Concommitant with this, the knowledgeable therapist could get the SSS client to act out situations demanding elaboration of cultural traits such as *machismo* or *personalismo* in order to better understand points of conflict between the SSS client's cultural values and those of the dominant majority culture. To illustrate this point, Abad and others (1974) note that conflict with the *respecto* concept is particularly common in parent-child relationships among Puerto Ricans on the mainland. As Abad and his colleagues state:

> Influenced by their Anglo peers, children, especially adolescents, strive to be more independent and rebel against restrictions that they might well accept if living on the island. An unknowing therapist in such a situation may too quickly conclude that the adolescent is acting appropriately against rigid expectations, and in so doing, the therapist may alienate himself from the parents, make them defensive, and ruin any chance for further family intervention. (P. 588)

In addition, the family adaptation model would extend to the architectural design of community mental health centers. There is evidence suggestive of the fact that centers with "living room" reception areas appear to be the most attractive to SSS clientele (e.g., Phillipus, 1971). This homelike informality becomes even more attractive, of course, when the SSS patient is greeted by someone who speaks his own language and who can evaluate the problem rapidly and who can implement immediate disposition. This kind of action based on *personalismo* is very similar to the kind of brokerage system employed in Latin America and to which many SSS clients are accustomed.

Barrio Service Center Model. New centers should be situated in the appropriate neighborhoods. Centers established at a distance from the target population must "attract" clientele—possibly by following a business model. Possibilities include arranging transportation (e.g., a busing service or perhaps a patient share-a-ride system), providing child-care facilities for parents (e.g., at the center or home-visit

"babysitters"), encouraging regular attendance at therapy sessions (e.g., through reduced fees, by remaining open "after hours").

Two clinics located in high-density population urban areas (Abad et al., 1974; Schensul, 1974), report remarkable success by "word of mouth" advertising among their Spanish-speaking clientele. While this informal communication network generated self-referrals in a more sprawling geographic area with a smaller population (south Tucson, Arizona), Burruel (1972) describes a "tremendous" response to an announcement of services on the Mexican radio stations. The inference of significance is clear. If mental health centers for the SSS are to fulfill the purposes for which they are designed, they must exert effort to contact the target population.

The next consideration involves the selection procedure of community representatives to serve as paraprofessionals, and the nature of the training program designed for them. Both Abad and others, (1974) and Burruel (1972) agree that faith healers and other practitioners of folk medicine are highly qualified as students for paraprofessional training programs. These individuals already enjoy some degree of community acceptance and probably possess skill in responding appropriately to human problems. This statement should not be misconstrued as indicating that ethnic minority group membership is a necessary condition for therapeutic effectiveness. As Sue (1973) has demonstrated, it is possible to develop highly sophisticated and effective training programs to train ethnic minority group students to serve as counselors for clients from their own ethnic minority group. Programs of equivalent validity must be developed for the SSS, and it is assumed that the efficacy of any paraprofessional will be related to the quality of whatever program is created for training purposes.

At this point, we shall expand on some of the recommendations presented above that deal with treatment programs. "Crisis intervention" may be defined and applied in a number of ways helpful, or even crucial, to the continued well-being of patients but which fall well outside the optimal (or even usual) models of mental health care. Imagine, for example, a widow whose sole source of support is her monthly welfare check. Should this check be delayed only a few days, this family may be literally in a "crisis." A center sensitive to the needs of the target population in this hypothetical instance might furnish emergency funding, might contact tradesmen to request credit, might implore creditors to wait a "few more days," or might ask the welfare agency for immediate reimbursement. Since this type of crisis intervention does not require professional education, this hypothetical patient

could be rendered a tremendous service by a paraprofessional who spoke her language, grasped her plight, was knowledgeable concerning other community agencies, and who responded immediately.

This type of "crisis intervention" represents the flexibility that community mental health centers must adopt if they are to respond appropriately to the human problems of the SSS. This point is elaborated in great detail by several writers (see especially Martinez, 1973) who agree that intrapsychic conflict represents only a small portion of the numerous human and social problems which trouble the SSS.

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SECTION II

INNOVATIONS OF DIAGNOSTIC INSTRUMENTS

PERSONALITY ASSESSMENT AND TEST INTERPRETATION OF MEXICAN AMERICANS: A CRITIQUE

Amado M. Padilla
Department of Psychology
University of California
Los Angeles, California

Rene A. Ruiz
Department of Psychology
University of Missouri
Kansas City, Missouri

The most recent frequency count cited by Buros (1970) indicates that 18,300 references related to personality assessment have appeared since 1938. A search of this literature indicates that only twelve of these articles describe the performance of Mexican American subjects on personality tests. Of these, however, several are only tangentially related to the topic to be discussed here (Fisher, 1967; Mote, Natalicio, and Rivas, 1971; Roberts and Erickson, 1968; Swickard and Spilka, 1961; and Zunich, 1971). This review will focus only upon those articles of direct relevance to the personality assessment of Mexican Americans.

It appears that the interpretation of personality test responses from Mexican American subjects are based on an implicit assumption that this group is somehow "no different" from the majority group. Another way of presenting the same assumption is to assert that cultural differences exert minimal influence upon personality test responses; therefore, "unique," "unusual," or "atypical" response patterns obtained from these subjects have the same meaning as they would among subjects who are not of Mexican origin. That is, such patterns would be interpreted as representing some form of individual deviance (e.g., "psychopathology"). To be explicit, a percept of the Rorschach such as "the evil eye" would ordinarily raise questions about paranoid ideation; however, among some Mexican Americans who subscribe to beliefs in folk magic (Kiev, 1968), this percept may have a more benign connotation. The purpose of this critique is to evaluate this assumption in the context of the limited amount of relevant empirical data. It is further the intent here to offer recommendations for the improved use of assessment techniques so that culturally sensitive interpretations may follow when one is working with a Mexican American population.

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Review of Literature

Projective Tests

The earliest two articles report work on the Rorschach (Kaplan, 1955; Kaplan, Rickers-Ovsiankina, and Joseph, 1956). In both studies, Rorschach performance was compared between two subcultural groups which possessed more "cultural integrity" than two other groups who were more acculturated to the larger society (i.e., Navaho and Zuni *vs.* Mormons and Mexican Americans). On the assumption that veterans will have had greater exposure to the majority group culture than nonveterans (i.e., are more acculturated), these four groups were also subdivided on the basis of military experience.

Several reservations must be stated concerning the first study before citing conclusions. Many users of the Rorschach have assumed that the instrument is "culture-free," in the sense that it could presumably provide insight into an individual's personality structure which was "uncontaminated" by culture or ethnic group membership. Kaplan (1955) rightly rejects this assumption and uses the instrument in an effort to detect precisely these kinds of differences. The problem comes in interpretation. If and when differences appear, there may be some difficulty in determining whether they are due to individual personality, culture-group membership, personal experiences with the majority group, some other extraneous variable, or the interaction of all these factors.

Despite these reservations, Kaplan's data suggest that more acculturation through military experience influences Rorschach performance. Specifically, veterans perceived "human movement" with greater frequency and relied more often upon "color" to explain their precepts. It is suggested, with appropriate caution, that these differences may reflect more creativity and extroversion among veterans from these culture groups.

The second study (Kaplan, Rickers-Ovsiankina, and Joseph, 1956) is more relevant. From the pool of multicultural Rorschach protocols described above, Kaplan and his colleagues selected records of six veterans from each of the four cultural groups. Two judges performed a series of sorting tasks with the twenty-four records. One judge, who knew which cultures were represented and who had personal experience with all four, achieved considerable success in sorting Rorschach records into the correct cultural groups. The second judge, who was only informed that the Rorschach protocols could be sorted into distinct categories without knowledge of the groups involved, was unable to sort

the records into meaningful groups. On the basis of this finding, Kaplan and his co-workers conclude that they have provided modest support for the idea that cultures manifest "modal personality" patterns, since Rorschach responses from the Mexican American group were "unique" and "homogeneous" enough to be discriminated from one Anglo American and two Indian groups.

The reader should be cautioned against unequivocally accepting these findings, since Kaplan and his colleagues state, in their discussion of the results,

> The only systematic difference that is striking to us is the apparent lack of involvement and motivation for outstanding performance on the part of many [Mexican] Americans . . . the [Mexican] American subjects appeared not to be more than superficially involved, and were not attempting to give more than a minimum number of responses to the tests. (P. 179)

This "lack of involvement and motivation" raises additional problems of interpretation. To what extent was the Mexican American culture correctly identified on the basis of decreased frequency of percepts? And why were these Mexican American subjects motivated to respond in this fashion? One possibility is decreased verbal fluency, another is lack of interest in the task, and there are doubtless other possible explanations. The problem is that we cannot evaluate whether fewer Rorschach responses in this case reflect a common cultural trait, individual personality differences, or just indifference toward an examination procedure perceived as meaningless.

Nevertheless, we shall proceed to a subsequent study of the Rorschach and Thematic Apperception Test (TAT) responses from Negro, Mexican American, and Anglo psychiatric patients. In this study, Johnson and Sikes (1965) compared the responses of twenty-five Ss from each ethnic/racial group. Subjects were matched for age, educational background, and occupational level.

Numerous statistically significant differences appeared between groups. The most distinct differences on the Rorschach appeared on the measures of hostility. The Mexican American group was high on Potential Hostility, while the Negro subjects were high on Victim Hostility. Interesting group differences emerged from the TAT. Among the most clear-cut differences were those related to "Family Unity." Mexican Americans consistently viewed the family as unified. Furthermore, the Mexican American group clearly differed from the other groups in mother-son and father-son relationships. Mexican Americans

consistently described the mother as nobly self-sacrificing and the father as authoritarian and dominant.

The major point from the Johnson and Sikes investigation for the purpose of this review is the finding that Mexican American patients manifest a unique pattern of responses to both projective devices.

Fabrega, Swartz, and Wallace (1968), as part of a larger investigation of ethnic differences in psychopathology, administered the short version of the Holtzman Inkblot Test to nineteen Anglo American, Mexican American, and Negro hospitalized schizophrenic patients. The results indicated that the projective data did not differ appreciably between the three matched patient groups. Nonetheless, ratings of psychopathology made independently by resident psychiatrists and nurses suggested that the Mexican American schizophrenics were more clinically disorganized and regressed than the other two patient groups. Although Fabrega and others do not explain this apparent discrepancy, they do suggest that the Mexican American Ss in their study may have been "sufficiently acculturated to Anglo patterns and values to no longer show the projective responses typical of Mexicans" (p. 232).

Objective Tests

A unique response pattern among Mexican Americans was also found by Mason (1967) in a study employing the California Psychological Inventory (CPI), an objective personality inventory. Subjects were thirteen- and fourteen-year-old American Indian, Caucasian, and Mexican American disadvantaged junior high students participating in a summer educational-enrichment program. It is beyond the scope of this critique to attempt to cite all the significant findings which emerged from the statistical analyses. Suffice to state that Mexican American males and femals manifested response patterns which were different from each other as well as different from those of the other two groups. Of perhaps even greater relevance here is the observation that

> The limited verbal facility of the present population necessitated modification of the usual administration . . . and . . . the test was administered in six separate sessions, allowing time for completion and opportunity for assistance with unfamiliar vocabulary. (P. 146)

To enable the reader to decide the validity of this type of test for the Mexican American, consider Mason's statement that

> One Mexican girl initially responded to the item, "I think Lincoln was greater than Washington," by stating that she could not answer because she had never been there! (P. 153)

In a study of social adjustment required by certain specified life-change events, Komaroff, Masuda, and Holmes (1968) compared the responses of Negro, Mexican American, and white Americans on the Social Readjustment Rating Scale. Subjects were instructed to rate a total of forty-three "life-change events" (e.g., "death of spouse," "divorce," "marital separation"). Despite some significant sampling errors, such as overrepresentation of Negro and Mexican American females, several highly relevant findings emerge. Although all three groups ranked the items in a similar fashion, the Negro and Mexican Americans were more alike than the white American middle-income group. Examination of content indicates that both Negroes and Mexican Americans rated items relating to labor and income (e.g., "mortage greater than $10,000," "major change in work responsibilities") as much more stressful (i.e., requiring greater readjustment) than did the white majority group. Komaroff and his colleagues suggest that these differences occur because of impoverished conditions that American ethnic minority group members experience. The authors related this to the "culture of poverty" wherein the minority group members exist in a cash economy while they remain impoverished (Lewis, 1966). Another finding is that Mexican Americans rate items such as "death of a close family member," "death of a spouse," or "major personal injury or illness" as *less* stressful than do Anglos or Negroes. The interpretation is that the Mexican tradition of the extended family offers solace upon which Anglos and Negroes cannot rely.

The final and in some ways the most telling comment about this study involves language fluency. Clearly referring to ethnic minority group subjects, Komaroff and others state that their questionnaire

> As originally worded, contained some language which, in trial runs, was not understood by many of those asked to read and complete it. For this reason, the wording was simplified on certain items . . . (P. 122)

Furthermore, Ss were

> Given a verbal synopsis of the instructions . . . rather than the written instructions such as had been given to the white American group . . . because many Ss balked at having to read detailed instructions. (P. 123)

Once again, these points lead us to question the validity of a paper-and-pencil questionnaire for Mexican Americans. Since some Mexican Americans are only monolingual in Spanish or only partially bilingual, the translation of tests or substitution of oral instructions for written ones may seem necessary to the investigator. However, such practices are hardly advisable in the absence of normative data on translated tests or on tests with unstandardized test procedures.

In a recent study, Reilley and Knight (1970) used the Minnesota Multiphasic Personality Inventory (MMPI) to investigate personality differences between freshmen with Spanish surnames and those without at a southwestern American university. Of thirty-six comparisons, several showed significant differences between the two groups. The Mexican American group scored higher on the L (lie) scale of the MMPI, which was interpreted as suggestive of more strict moral principles or overly conventional attitudes. Similarly, the non-Spanish surnamed group scored higher on the Pa (paranoia) scale, which was taken to be indicative that they were more subjective, sensitive, concerned with self, and less trusting.

It was also found that Mexican American males and Anglo American females scored higher than their counterparts on: (a) Pt (psychasthenia), indicating worry and anxiety; (b) Sc (schizophrenia, reflecting social alienation, sensitivity, worry, and the tendency to avoid reality by use of fantasy; and (c) Si (social introversion), tendency toward introversion, modesty, and shyness.

Caution must be exercised in the acceptance of these personality differences, since Reilley and Knight themselves conclude that

> A sophisticated interpretation of individual profiles should include consideration of the total pattern of scales within the context of other pertinent information about the individual . . . particularly . . . college students. (P. 422)

Discussion and Recommendations

The near absence of research on the personality assessment of Mexican Americans should not be taken to imply that inferences cannot be made concerning the performance of Mexican Americans on such tests. To begin, it appears that no projective test can be considered "culture free" and that it is possible that Mexican Americans will respond differently on these instruments. This should not be misinterpreted, however, as implying that projective-test protocols from this subject population are grossly different from those obtained from majority group members. Rather, subtle differences probably exist—perhaps in content, style, latency, frequency, or other response variables which can conceivably lead to misinterpretation—and these cultural differences can be misconstrued as individual "assets" or "liabilities." Speculation aside, it is clear that well-controlled studies employing Mexican American subjects on a variety of projective devices are needed.

Let us proceed to examine how Mexican American subjects appear "unique" in responding to the Rorschach and TAT. As noted earlier,

Kaplan and his co-workers indicate that they are struck by "the apparent lack of involvement and motivatoin among the Mexican Americans" (p. 179). These authors state that their subjects "appeared not to be more than superficially involved, and were not attempting to give more than a minimum number of responses" (p. 179). Of major importance here is that Kaplan and his co-workers recognize their inability to determine whether such a response pattern "reflects personality characteristics . . . or . . . stereotyped attitudes in the culture" (p. 179). Thus, data are available indicating that Mexican American respondents are underproductive in terms of mean number of Rorschach percepts. Therefore, it seems reasonable to predict a similar response pattern on other projective tests (e.g., shorter answers on Incomplete Sentence Test, shorter stories on thematic tests, etc.). This conclusion suggests that the Mexican American patient who is terse in response to projective tests may not necessarily be less intelligent, less fluent, or more "defensive."

The Johnson-Sikes analysis of Rorschach responses denoting attitudes toward hostility suggests that Mexican Americans feel "secure, but yet, defensively on guard" (p. 186). Their analysis of TAT stories obtained from these same subjects indicate a "more consistent view of the family as unified" (p. 187). In response to a picture depicting a Mother and Son (TAT: 6BM), Mexican Americans typically describe a son leaving the mother while both experience sadness. There are other differences, but these appear adequate to make the point. In responding to these two projective tests, Mexican Americans appear to handle themes of anger and inter-familial relationship differently from Anglo or Negro Americans. As stated earlier, this conclusion may also apply to other projective tests. Given these findings, diagnosticians using projective test data to infer psychopathology from Spanish speaking patients should exercise caution, since the relevant normative data have yet to be gathered.

Now let us consider the three studies using objective psychological inventories. First, as with projective tests, there is evidence that Mexican American Ss, ranging in age from thirteen to eighty years, respond differently to objective inventories than one might predict from normative data. The need for additional research is critical, but obvious, and is being repeated only to stress its importance.

A second very significant conclusion emerges from these studies. Note that Komaroff and others and Mason modify test instructions in order to create motivation and enhance communication. It is clear that instructions standardized on college sophomores or middle-class Ss are not appropriate for use with Mexican Americans. This observation is

particularly critical because these tests are designed for use with "normal" Ss and were, in fact, used in this way. In other words, one may not argue that excessive stress associated with psychological or emotional problems disrupted test performance. Translations from English into Spanish may, or may not be, effective. Only additional research can answer this question.

Now we return to the basic question of assessing severity of psychopathology among Mexican American psychiatric patients. Having discussed projective techniques and objective inventories, we shall focus upon the use of paper-and-pencil instruments. The absence of normative data on paper-and-pencil tests for Mexican Americans is particularly critical, since such instruments are frequently used as rapidly and economic means of evaluating potential clients to a psychiatric clinic.

In many psychiatric and community mental health clinics, the initial test evaluation of a new client begins with the administration of some type of "basic battery" of psychological tests. In settings dealing with functional disorders, these batteries typically include some type of printed form eliciting biographical information, a "quick form" of some paper-and-pencil test of intelligence, an objective personality inventory (usually the MMPI), and a semiprojective measure of personality (e.g., one of the many available Incomplete Sentence Tests, or, less often, some type of human figure drawing). A client's performance on batteries such as these is extremely important, since it is used to determine whether treatment will be offered, and, if so, what type. For example, clients who obtain low I.Q. scores and who manifest limited verbal fluency would probably not be recommended for the type of intensive insight psychotherapy which provides skill in human problem solving. And yet such a performance typifies what one would predict from a psychiatric patient who is Mexican American. Thus, while there is already some doubt about the adequacy of mental health treatment for the Mexican American population (Karno, 1966; Kline, 1969; Phillipus, 1971), there are also no data correlating performance on "basic batteries" with response to treatment.

Rather than issue a general recommendation for "more research," we will attempt to specify more precise goals. Research is needed which compares test performance as a function of English and/or Spanish instructions. Careful attention must be paid to the wording of items, not only in terms of difficulty of reading level but also with regard to ease of translation. In addition, there is increasing reliance upon computer technology in the administration, scoring, and interpretation

of psychological test protocols. A number of computer programs are available, for example, which print out psychological reports based on client responses. Some of these programs, but not all, utilize actuarial approaches such as "code type" interpretation of the MMPI. Yet none of these computer programs has norms specific to the Mexican American population. The thrust of all these observations is to emphasize the need for normative studies of personality assessment instruments for Mexican American Ss.

Finally, research is needed to determine the influence of examiner characteristics on psychological test performance among Mexican Americans. It is extremely difficult to formulate hypotheses with precision, however, because of the paucity of relevant research. A recent review of the literature pertaining to the mental health of Americans who are "Latino," or Spanish speaking, Spanish surname (Padilla and Ruiz, 1973) failed to reveal any studies which dealt specifically with examiner effects on test performance among Mexican Americans. We would suggest that ethnicity, age, sex, and socioeconomic status (i.e., "Class") *of examiner* are variables with potential influence upon the personality test performance of Mexican American Ss. For example, we would speculate that very young Mexican American children would respond to older examiners, regardless of sex, with the "respect" Latin cultures typically express toward elders. On the other hand, Mexican American males approaching pubescense might respond differently than Mexican American females of the same age by reacting to a relatively young examiner in a manner which appears "rebellious," "insolent," or "flirtatious." At the risk of confirming the obvious, these are problem areas requiring extensive research exploration to ensure the validity of personality assessment among Mexican Americans.

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SECTION III

DEVELOPMENT OF COMMUNITY SERVICE PERSONNEL

MEXICAN AMERICAN AND ANGLO AMERICAN REACTIONS TO ETHNICALLY SIMILAR AND DISSIMILAR PSYCHOTHERAPISTS

Frank X. Acosta
Department of Psychiatry
University of Southern California School of Medicine
Los Angeles, California

Among minority groups, the Mexican American appears to be one of the least represented in mental health services (Padilla and Ruiz, 1973). This underrepresentation seems to be even worse in the Mexican American's participation in psychotherapy (Karno, 1966; Yamamoto et al., 1968). Many questions are raised by the Mexican Americans' lack of participation in mental health services concerning their mental health needs and their attitudes toward mental health services. At present, however, little empirical research exists which helps to understand why the Mexican American is so minimally involved in mental health services.

It is the purpose of this paper to examine the Mexican American's perception and use of psychotherapists and psychotherapy. It is felt that the client variables of preference and ethnicity, along with the therapist characteristics that may interact with these variables, are important to the successful initiation and process of therapy. A study and its findings will be presented which examine the effects of the psychotherapist's ethnicity and expertise (professional *vs.* nonprofessional) on the self-disclosures and attitudes toward the therapist by Mexican Americans and Anglo Americans.

Need for Services

As the nation's second largest ethnic minority, Mexican Americans, known also as Chicanos, have clearly been a disadvantaged group. This population has been discriminated against by the larger Anglo American

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society and finds itself significantly lower than the dominant society in housing, education, occupations, and income (Grebler, Moore, and Guzman, 1970). These conditions certainly appear to place the Mexican American people in a particularly vulnerable position to experience psychological distress. For example, several major urban studies have demonstrated that low socioeconomic status is associated with a high incidence of psychiatric problems (Hollingshead and Redlich, 1958; Srole et al., 1962).

In addition to being subject to prejudice and widespread poverty like the Negro, the Mexican American has further experienced difficulties with acculturation and with communicating effectively in English. Several studies have suggested that conditions of acculturation can facilitate psychological distress for individuals of ethnic minority groups (Fabrega and Wallace, 1968; Dworkin, 1965).

Although there are no rigorous research studies to support the hypothesis that the process of acculturation can be debilitating for some groups and individuals, it seems plausible that finding one's established cultural traits and values in conflict with those sanctioned by the larger dominant society can be potentially disturbing. Murillo (1971), for example, has argued that many young Mexican American patients in therapy have been found to suffer from the pressures of an identity crisis that is compounded by doubts about the worth of their own ethnic origin.

As indicated above, the Mexican American is indeed subject to special conditions of psychological stress. While the incidence of serious or incapacitating psychological disorders among Mexican Americans is not known, it is misleading to argue that Mexican Americans suffer from less serious psychological problems and disorders than do Anglo Americans or other ethnic groups because they are not represented in psychiatric clinics and hospitals. Yet this latter argument has been advanced by some authors. Jaco (1959), for example, found an underrepresentation of Mexican Americans among patients admitted for psychosis to hospitals in Texas and concluded that Mexican Americans suffer from less severe psychiatric disorders than do Anglo Americans. As Padilla (1971a) has stressed, a nationwide epidemiological survey still needs to be done in order to determine the incidence and prevalence of mental disturbance among Mexican Americans.

Impact of Social Class

Since the Mexican American population is clearly identified with a low socioeconomic status, it is important to consider how the client's social class affects his participation in therapy. A major criticism of psychotherapy has been that it is traditionally available only to a highly

select group of clients. Hollingshead and Redlich's (1958) findings strongly pointed out that different social classes were apparently receiving different kinds of treatment, with long-term psychoanalytic treatment being offered primarily to middle- and upper-class clients. Studies of public outpatient clinics have also revealed significant relationships between social class and actuarial variables—such as race, age, socioeconomic level, education, and I.Q.—and referral or acceptance for psychotherapy (Brill and Storrow, 1960; Rosenthal and Frank, 1956). Thus, it seems that the client's particular social-class characteristics affect his acceptance into therapy. But how does one's social class affect the actual process and outcome of therapy?

Several studies have suggested that one's socioeconomic class and race have major effects not only on selection to therapy but also on continuation and outcome in therapy (Brill and Storrow, 1960; Carkhuff and Pierce, 1967; Imber et al.,1955; see Garfield, 1971, for a thorough review of the effects of social-class variables on psychotherapy). In the study by Imber and others (1955) it was found that lower-class patients significantly terminated therapy sooner than middle- and upper-class patients. It is important to note that the therapy offered was of a psychodynamic modality which may not have been amenable to the life-style needs of the lower-class patients.

The success of therapists who have modified their traditional approaches to meet client needs has been demonstrated in several studies (Goin et al., 1965; Gould, 1967; Baum et al., 1966). For example, Gould (1967) found that blue-collar workers responded better to therapy when the therapist was more informal, flexible, directive, physically active, concrete, and willing to meet outside of the consulting room.

It seems that therapists must greatly reduce the influence of their own value systems in their communications with lower-class clients in order to be effective with them.

Use of Services

Does the Mexican American perceive psychological problems in a way that minimizes them, thereby excluding himself from psychiatric help? Karno and Edgarton (1969) interviewed large groups of Anglo Americans and Mexican Americans of similar socioeconomic status and residing in the same community, in an effort to determine how these people perceive and respond to "mental illness." These investigators concluded that the two groups did not differ significantly in their perceptions and definitions of mental illness. A further finding was that even though the majority of either group was not able to name or locate a single psychiatric clinic, the majority of both groups felt that a

psychiatric clinic could help a person with a psychiatric disorder. The main implications from this study are that Mexican Americans are no different from their Anglo counterparts in identifying at least severe kinds of psychiatric disorders and in seeing psychiatric facilities as sources of help for these disorders. It is not clear, however, to what degree Mexican Americans perceive psychiatric clinics as useful in regard to a psychological impairment that would not be categorized as a severe disorder. Further research is needed to evaluate Mexican American attitudes and perceived resources for such predominant nonpsychotic problems as situational reactions, depressive reactions, anxiety reactions, and sexual dysfunctions.

The Karno and Edgarton (1969) finding that Mexican Americans see psychiatric clinics as useful for some problems further underscores the contradictory and striking underrepresentation of Mexican Americans in psychiatric settings. Basing their findings on a large sample of Mexican Americans residing in a *barrio* in Los Angeles, Edgarton and others (1970) provide a possible explanation for this underrepresentation. Subjects in this study specified physicians as the favored treatment resource for "mild, moderate, and severe mental illness." In a survey of a random sample of private general physicians in a *barrio* of Los Angeles, Karno and others (1969) found that the majority of these physicians reported that they were providing chemotherapy and very brief supportive help to some of their Mexican American patients who were experiencing emotional disturbances. These investigators concluded that this type of service was "grossly inadequate" but pointedly noted that they failed to find any other institution in the community which was as active and available a source of help for emotional disturbances. As in the Hollingshead and Redlich (1958) finding that the lower-class patients receive more chemotherapy and get labeled more often as psychotic than do the middle- and upper-class, who instead receive more psychotherapy and are seen as neurotics, it appears that Mexican Americans are primarily receiving chemotherapy from practitioners who are not psychiatrically trained. It further appears that major reasons for the underrepresentation of Mexican Americans in psychiatric facilities may lie in the fact that there is a conspicuous lack of these facilities in Mexican American communities (Morales, 1971), and that Mexican Americans may not be aware of those facilities that do exist (Karno and Edgarton, 1969).

Language

How much does language difficulty limit the Mexican American's use of psychiatric facilities? Some empirical data reported by Grebler, Moore, and Guzman (1970) strongly suggest the extent of this problem.

In their comprehensive study of Mexican Americans in Los Angeles and San Antonio, these investigators found that over half of the randomly interviewed respondents who were in the lower socioeconomic class had difficulty with English.

If the poor have traditionally been excluded from therapy, compounding poverty with a language barrier certainly reduces the possibility that a Mexican American with this combination of factors will achieve much communication with an Anglo non-Spanish-speaking therapist. But would conditions be very different if Anglo therapists who see such a client were themselves able to speak Spanish adequately? Unfortunately, no empirical data are available in the literature to help answer this question.

Self-Disclosure Styles

It would be important to consider at this point how the self-disclosing styles of Mexican Americans may be related to their poor use of psychotherapy. Some of the studies conducted by Jourard and his associates (Jourard, 1971) to evaluate comparative cross-cultural levels of self-disclosure have tentatively indicated that blacks and Puerto Ricans are less inclined to reveal personal information to others like their friends and parents than are Anglo Americans, at least among college students. To date, no study has adequately surveyed the self-disclosure styles of male and female Mexican Americans of different socioeconomic and Mexican generation backgrounds. Such an empirical study needs to be done in order to more fully understand the Mexican Americans' self-disclosure tendencies, tendencies that could greatly affect their use of psychotherapy.

Mental Health Treatment

What kind of treatment does the Mexican American encounter when he does seek professional psychiatric assistance? Several authors have asserted that the Mexican American is generally not involved in psychotherapy even when the clinics are free and located near Mexican American communities (Kline, 1969; Yamamoto et al., 1968). Kline (1969) has placed much of the burden for this situation on the Mexican Americans' negative stereotypes of the Anglo American. *Anglo American,* it should be noted, is typically the mental health professional's identification (*Anglo American,* in this case, and throughout this discussion, refers generically to white Americans who are not Spanish surnamed). Basing much of his argument on Simmons' (1961) study of the Mexican American's perception of the Anglo American, Kline posited that the Mexican American's expectation that the Anglo

American will be "cold, unkind, mercenary . . . and insincere" presents a serious problem for Anglo American mental health professionals. The implication here is that it is the Mexican American who is not making himself amenable to participating in psychotherapy because of his prejudicial rejection of the Anglo American. This proposition may prove to be a fruitful one and deserves empirical investigation. Unfortunately, no systematic research has been done to explore this hypothesis.

In a study which suggests the converse of Kline's position, Yamamoto and others (1968) report a nine-month follow-up of a large group of low-socioeconomic-class patients seen in a public psychiatric outpatient clinic located close to a major *barrio* in Los Angeles. The results indicated that the type and length of treatment offered to Anglo American, Negro, and Mexican American patients by Anglo American therapists did differ dramatically for the three groups. More specifically, Mexican Americans and Negroes were more often discharged after the first interview or seen for minimal supportive psychotherapy and chemotherapy, whereas Anglo Americans were more greatly involved in long-term intensive therapy. Karno (1966) has also reported that in spite of similar low-social-class status, Anglo American patients received significantly more individual therapy than either Mexican American or Negro patients in a public psychiatric outpatient clinic. The strong implication from the Karno and the Yamamoto studies is that it is not only the social class of the ethnic patient which excludes him from quality psychiatric treatment, but his very ethnic identification as well.

Client Perceptions of Psychotherapists

What effects do the client's perceptions of his psychotherapist have on his initial involvement and on the process and outcome of his treatment? Answers to this question would seem to be important for a study of client participation in psychotherapy, whether by Mexican Americans or any other group of people. Only a few investigators, however, have recently begun to study systematically the different characteristics of therapists which lead to preferential selection by different clients. For example, the effects of such therapist characteristics as age, sex, race, physical disability, and profession on the client's preference for the therapist have been the focus of several recent studies (Edelman and Snead, 1972; Boulware and Holmes, 1970; Brabham and Thoreson, 1973; Wolkon, Moriwaki, and Williams, 1973). With the exception of Wolkon and others' (1973) study, most of these studies have relied on the responses of presumably white middle-class college students.

The effects of ethnic or racial similarity or dissimilarity between therapist and client on the effectiveness of psychotherapy have been examined empirically in only a few studies. Most of these studies have dealt with black clients and have been conducted on a small scale. Yamamoto and others (1967) found that high-ethnocentric white therapists, as determined by the Bogardus Social Distance Scale, showed poorer results or earlier drop-outs with black than with white patients. Unfortunately, the criterion for distinguishing between high- and low-ethnocentric therapists was not clear, and thus limits any generalization from the study. In a small-scale study, Carkhuff and Pierce (1967) investigated the effects of race and social class of therapists and patients upon patient depth of self-exploration. The authors found that both blacks and whites showed more therapeutic change with therapists of similar race and social-class status. In a study of the effects of racial matching with black patients, Banks, Berenson, and Carkhuff (1967) found a black nonprofessional to be as effective with black patients in an initial interview as were white therapists with varying levels of training.

In a questionnaire study with black and white female college students, Wolkon, Moriwaki, and Williams (1973) found racial differences in preferences for psychotherapists. The authors found that black females significantly preferred black therapists, while white females showed no racial preference. It was speculated by Wolkon and his co-workers that social desirability may have accounted for the neutral position shown by the whites. Black lower-class subjects were found to hold more negative attitudes toward psychotherapy than either black or white middle-class subjects. Like the findings of Carkhuff and Pierce (1967) and of Banks and others (1967), Wolkon and others' (1973) findings suggest that blacks may have strong preferences for black therapists and may profit more in therapy through a racial match. Wolkon and others' (1973) findings imply also that a person's social-class identity may be more important than race in attitudes toward therapy.

To date there is no empirical study reported in the literature which has attempted a direct examination of Mexican American preferences and attitudes for racially or ethnically similar or dissimilar therapists. The literature on Mexican American participation in therapy is largely based on individualized clinical reports and on questionnaires which only deal remotely with the problem of racial and ethnic differences between therapists and clients.

The responses of minority clients to receiving psychiatric help from nonprofessionals seems to have been overlooked by mental health

investigators. Only a few studies have investigated this subject (e.g., Banks et al., 1967). The recent popularization of the nonprofessional for helping to meet the mental health manpower needs (Guerney, 1969) and the encouraged use of this kind of therapist for Mexican Americans (e.g., Padilla, 1971b) and for other minorities (Sue, 1973) calls for increased study of how individuals of disadvantaged and minority groups actually respond to the nonprofessional or the professional.

Overview of the Study

In an effort to partially answer the question "What kind of therapist works best with what kind of Mexican American client?" a study was undertaken to examine the effects of psychotherapist ethnicity and expertise on the self-disclosures and preferences toward therapists of Mexican Americans and Anglo Americans.

The procedure of this study entailed differential introductions to a taped therapist and the contrast in his speech accent. Mexican Americans and Anglo Americans listened to one of two matched therapy tapes containing the same dialogue. The tapes presented a therapist working for the first time with an anxious, depressed, and, at times, angry young man. Therapist responses included questions, silences, and reflections. In one tape the therapist spoke fluent English with a slight Spanish accent, in the other he spoke fluent English with a standard American accent. Only two tapes were actually prepared. The therapist was identified as being in one of four categories: Anglo American professional, Anglo American nonprofessional, Mexican American professional, Mexican American nonprofessional. The same therapist was introduced as either a professional ("Dr.") or as a nonprofessional ("Mr."), with corresponding high and low descriptions of his expertise. When the therapist spoke English with a slight Spanish accent, he was identified by a common Spanish name and it was stated that his parents came from Mexico. In contrast, when the therapist spoke English with no Spanish accent, he was identified by a common Anglo American name and it was stated that his ancestors came from northern Europe before the Civil War. After hearing a tape of the therapist working with a disturbed young man, subjects were asked to indicate on a self-disclosure scale, their degree of willingness to talk to the therapist they had just heard. Subjects were also asked to indicate on rating scales their attitudes toward the therapist. Additional data included ratings of attitudes toward psychotherapy and test scores on self-esteem.

The general hypotheses of this study were twofold: (1) Mexican Americans and Anglo Americans would respond differentially to

psychotherapists who were introduced as either high or low experts (professional or nonprofessional); and (2) Mexican Americans and Anglo Americans would respond differently and distinctly to therapists who differed in their ethnic identification as either Anglo American or Mexican American.

Method of Investigation

Subjects

The subjects were 187 undergraduate college students. Ninety-four were Mexican Americans from East Los Angeles College, 52 male and 42 female. Ninety-three were Anglo Americans from Santa Monica College, 39 male and 54 female. East Los Angeles College is a junior college located in a Mexican American community with a majority enrollment of Chicano students. Santa Monica College is a junior college located in an Anglo American community with a majority enrollment of Anglo American students. All subjects were native-born Americans fluent in English. Anglo Americans were defined for purposes of this study as white Americans, chiefly of northern European stock, who were not Spanish surnamed.

The subjects were all volunteer students from introductory psychology and sociology classes. The volunteer rate following classroom announcements of this research study was about 85 percent. No subjects indicated previous participation in a research study.

All subjects were assigned a socioeconomic status of High, Medium, or Low, based on the occupation of the head of their household, either father or mother. The three occupational ranks were those used by Hunt and Cushing (1970). The High rank included the professional and technical, self-employed businessmen, managers and officials occupational categories. The Medium rank included the clerical and sales, skilled workers, and protective workers categories. The Low rank included the semiskilled, operative and kindred workers, service workers, and unskilled laborers categories. Based on these parental-occupation ranks, Chicano subjects were grouped as follows: High rank, 7; Medium rank, 51; Low rank, 30; Undeclared, 6. Anglo subjects were grouped as follows: High rank, 38; Medium rank, 40; Low rank, 11; Undeclared, 4.

Apparatus

Two audio tapes of an enacted segment of a psychotherapy interview were produced. Actors were used to play the roles of therapists and clients. For the role of therapist, one male actor was used for the

two tapes. For the role of client, one male actor was used for both tapes. Both audio tapes were made from the same script to control for therapist and client responses and to present the same kind of therapeutic situation. Both the therapist and the client were trained so that their performances in the two audiotapes would be similar. The main difference between the performances by the therapist actor was that the therapist actor deliberately spoke with a slight Spanish accent in one tape and with a standard American accent in the other.

The therapist's performance in both tapes was rated as highly similar by five clinical psychology interns. Similar results were obtained for the client's performance.

The therapy tape presented an anxious, depressed, and, at times, angry young man participating in nondirective therapy. Therapist responses included questions, silences, and reflections.

Audio tapes were played on a cassette tape recorder.

Procedure

Subjects in either the Anglo American or the Mexican American ethnic group were assigned to one of four experimental groups. The experimental conditions involved presenting the subject with one of the two therapy tapes and manipulating the introduction of the taped therapist according to the assigned condition. More specifically, a subject was exposed to only one of the following four conditions: (a) Similar High Expert therapist; (b) Similar Low Expert therapist; (c) Dissimilar High Expert therapist; and (d) Dissimilar Low Expert therapist. In this study, "Similar" and "Dissimilar" refer to the degree of similarity in ethnic identification between the therapist and the subject. "High Expert" refers to the therapist's status as a professional, whereas "Low Expert" refers to his status as a nonprofessional.

Subjects were seated at a desk in a quiet room. The experimenter gave a general introduction to the study and stated that it was an attempt to see how people look at psychotherapy. According to which of the four conditions he was presenting, the experimenter then changed the introductions as follows.

1. Using the tape with the English-speaking, standard-American-accent therapist, the experimenter stated, for the conditions Similar High Expert for Anglo American subjects and Dissimilar High Expert for Mexican American subjects:

> You will now hear part of a psychotherapy session. The psychotherapist is Dr. William Jones, who has his doctor's degree from Harvard University in Cambridge, Massachusetts. He was born in this country. His

ancestors came from northern Europe before the Civil War. He is well known and well thought of throughout the United States for his work as a therapist. Besides practicing as a psychotherapist, Dr. Jones has lectured and taught other professionals at many universities on the subject of psychotherapy. The client he is seeing is a young man who has come on his own to see Dr. Jones for the first time.

2. Using the same tape as in (1) above with the English-speaking, standard-American-accent therapist, the experimenter stated, for the conditions Similar Low Expert for the Anglo subjects and Dissimilar Low Expert for the Chicano subjects:

> You will now hear part of a psychotherapy session. The psychotherapist is Mr. William Jones, who received his high school education in Los Angeles. He has also received several months of training in psychotherapy. He was born in this country. His ancestors came from northern Europe before the Civil War. Mr. Jones is well thought of by the staff in the center where he has worked for several years. The client he is seeing is a young man who has come on his own to see Mr. Jones for the first time.

3. Using the tape with the English-speaking, Spanish-accent therapist, the experimenter stated, for the conditions Similar High Expert for Chicano subjects and Dissimilar High Expert for Anglo subjects, the same as above in condition (1), with the therapist's name changed to Dr. Raul Sanchez and the ethnic identification changed to: "He was born in this country. His parents came from Mexico."

4. Using the same tape as in (3) with the English-speaking, Spanish-accent therapist, the experimenter stated, for the conditions Similar Low Expert for Chicano subjects and Dissimilar Low Expert for Anglo subjects, the same as above in condition (2), with the therapist's name changed to Mr. Raul Sanchez and the ethnic identification changed to: "He was born in this country. His parents came from Mexico."

For all four conditions, the experimenter then stated: "As you listen to the tape please try to put yourself in the client's shoes and try to get as much of a feel as you can for talking to the therapist, O.K.?" The experimenter then played a ten-minute tape.

After hearing the therapy tape, Subjects were presented with the self-disclosure sentence-completion blank, which contained twenty items. Some examples of the self-disclosure items are: "My face looks . . ."; "I feel blue when . . ."; "The opposite sex sees me . . .". The subjects were asked to think about each item in a personal way and to indicate on a 4-point scale the degree that they would be willing to talk about each item to the therapist they had just heard.

The experimenter then asked all subjects to indicate their feelings about the therapist and client. Eight items were rated on a scale from 1 to 6 for strength of agreement, ranging from "agree strongly" for 1 to "disagree strongly" for 6. The items dealt with the following: the subject's opinion of the therapist's competence, trustworthiness, and understanding; the subject's perceived similarity and attraction to the therapist; the subject's perceived similarity and attraction to the client; and the subject's judgment as to the client's degree of disturbance. Two additional items dealt with the subject's attitude toward therapy's utility, and the subject's perception of the client's ethnic identification.

The subjects were also asked to complete Bentler's (1972) Psychological Scale 24 as a measure of self-esteem. Bentler developed this scale with a large group of college students and found it to be high in validity and in internal consistency. Bentler obtained concurrent validity by correlating this scale with evaluations by peers. Bentler's scale was used in this study to determine whether any group differences between the subjects' self-disclosures were related meaningfully to self-esteem.

The subjects were thanked for their cooperation and participation. Any questions pertaining to the study were answered. The running time for this study was forty minutes.

Data Analysis

Factor analysis was used to study the pattern of relationships among the twenty items in the projective self-disclosure scale. Unweighted item scores were used throughout this data analysis. The factor analysis computed was orthogonal varimax rotation. Based on their content, the five factors found were named as follows: Personal Problem Factor (1), Sex Factor (2), Work Factor (3), Body Factor (4), and Dissatisfaction Factor (5).

An orthogonal varimax rotation procedure was also used to factor analyze the eight attitude-toward-therapist and -client items. This analysis revealed three attitude factors. These three factors were named: Attitude toward Therapist Factor (1), Attitude toward Client Factor (2), and Client Disturbance Factor (3). Since one item, Similarity to Therapist, loaded equally high on Attitude factors (1) and (2), it was not included in either of these factors and was treated as an independent item in all subsequent analyses.

The main analyses of experimental conditions were performed with a 2 x 2 x 2 Analysis of Variance (ANOVA). The independent variables were: Subject Ethnicity x Therapist Ethnicity x Therapist Expertise.

The main dependent variables were the self-disclosure scores, the attitude-toward-therapist scores, the attitude-toward-client scores, and the attitude-toward-psychotherapy scores.

Results

Self-Disclosure

Mexican Americans proved to be significantly lower in self-disclosure scores than Anglo Americans, as revealed by analysis of variance for all subjects. Socioeconomic status, as indicated by occupational rank, did not affect this result. Although both groups indicated a substantial willingness to disclose about themselves to the therapists, the Anglo Americans were somewhat higher.

Mexican Americans were found to disclose less to Chicano therapists than did Anglo Americans to Anglo therapists. This finding was in support of an initial hypothesis of the study. While Mexican Americans disclosed less than Anglo Americans, their mean disclosures also indicated a positive tendency to disclose "in general" to therapists. Sample differences that hinted at some preference for Chicanos to disclose more to Chicano therapists were not statistically significant.

Table 1

Means and Standard Deviation of Errors for Total Self-Disclosure scores by 94 Mexican American (Chicano) students and 93 Anglo American (Anglo) students. Four Therapist Conditions were: Anglo Professional, Anglo Nonprofessional, Chicano Professional, Chicano Nonprofessional. Each student was in one condition only. Minimum score possible: 20; Maximum score possible: 80. The higher the score, the higher the level of self-disclosure.

	Therapist Condition							
	Anglo Professional		Anglo Non-professional		Chicano Professional		Chicano Non-professional	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Mexican Americans	58.89	10.41	56.08	11.69	56.65	11.77	61.83	10.66
Anglo Americans	65.52	13.05	64.58	10.07	63.44	8.92	63.86	14.08

In Table 1 may be found the means and standard deviations for total self-disclosure scores for all subjects. The analysis of variance for total self-disclosure scores on all 187 subjects indicated a highly significant main group effect difference ($F = 12.99$, $df = 1, 179$, $p < .001$) in the direction of lower self-disclosure for the Mexican American group. Figure 1 presents the group differences in graphic form.

The results of analysis of variance determined that the above group effect held for the following four self-disclosure factors: Personal Problem Factor (1) ($F = 10.24$, $df = 1, 179$, $p < .01$); Work Factor (3) ($F = 16.10$, $df = 1, 179$, $p < .001$); Body Factor (4) ($F = 5.74$, $df = 1, 179$, $p < .05$); and Dissatisfaction Factor (5) ($F = 9.07$, $df = 1, 179$, $p < .01$).

Analyses of variance with subject sex as an added two-level factor revealed practically no sex differences in self-disclosure scores across all subjects. The only main effect found was on the self-disclosure Dissatisfaction Factor (5) ($F = 4.24$, $df = 1, 171$, $p < .05$), which revealed that females ($\bar{x} = 10.09$) were more willing to disclose on this factor than were males ($\bar{x} = 9.49$) across therapist conditions.

Socioeconomic Comparisons

In matching Mexican American and Anglo American subjects according to occupational rank, it was found that the only level that could be compared across therapist conditions was the Medium Occupational Rank. For the Low and for the High Occupational Ranks, the number of subjects was insufficient for comparison.

Allowing for a slightly lower main group effect F-ratio, probably as a result of a lower number of subjects available for the matched comparison, the results of the analysis of variance for total self-disclosure scores of subjects in the Medium Occupational Rank are the same as for the total sample: Mexican Americans disclose relatively less than Anglo Americans, though both indicate a substantial willingness to disclose to the therapist ($F = 4.53$, $df = 1, 82$, $p < .05$).

Based on socioeconomic comparisons done with analyses of variance for both Anglo American and Mexican American subjects, it was found that there were no major statistical social-class differences between the 38 Anglo Americans in the High Occupational Rank and the 40 Anglo Americans in the Medium Occupational Rank, nor between the 51 Mexican Americans in the Medium Occupational Rank and the 30 Mexican Americans in the Low Occupational Rank.

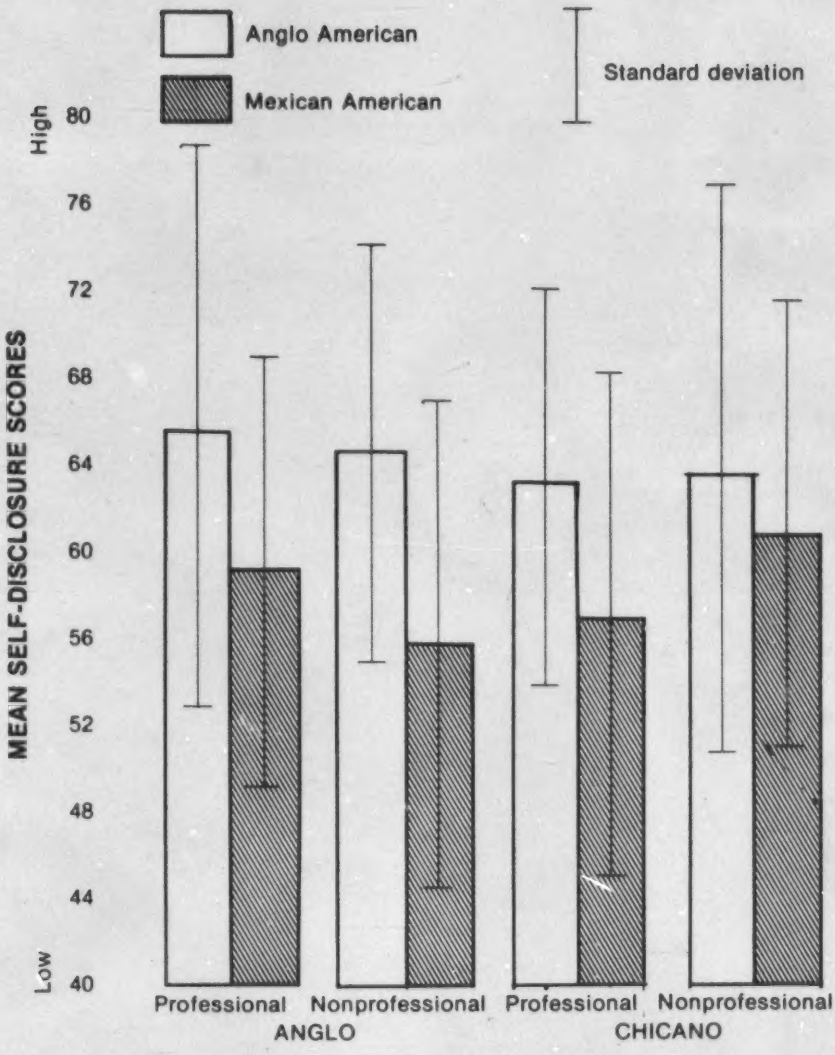

Figure 1. Means and Standard Deviations for Total Self-Disclosure Scores by 94 Mexican American (Chicano) students and 93 Anglo American (Anglo) students. Minimum score possible: 20; Maximum score possible: 80. The higher the score, the higher the level of self-disclosure. Overall group differences between the Anglo Americans and Mexican Americans were highly significant ($p<.001$).

Attitude toward Therapist

Both Mexican Americans and Anglo Americans were found to express more positive attitudes toward the Anglo American professional and to the Mexican American nonprofessional. While the analysis of variance for all subjects on the Attitude toward Therapist Factor (1) showed no ethnic group differences, it did reveal that the therapists were seen differentially by all subjects.

Both Mexican Americans and Anglo Americans showed differential preferences to the similarly behaving therapist who was given different ethnic and expertise identifications. It should be noted that while all subjects saw the Anglo professional and the Chicano nonprofessional more positively than either the Anglo nonprofessional or the Chicano professional, all therapists were seen with moderately positive attitudes. More specifically, therapists were perceived by both ethnic groups to be moderately skillful, trustworthy, understanding, and attractive.

Table 2

Means and Standard Deviation of Errors for Attitude toward Therapist Factor (1) scores by 94 Mexican American (Chicano) students and 93 Anglo American (Anglo) students. Four Therapist Conditions were: Anglo professional, Anglo nonprofessional, Chicano professional, Chicano nonprofessional. Each student was in one condition only. Minimum score possible: 4; Maximum score possible: 24. The lower the score, the more favorable the attitude toward therapist.

	Therapist Condition							
	Anglo Professional		Anglo Non-professional		Chicano Professional		Chicano Non-professional	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Mexican Americans	9.73	3.76	10.25	3.48	11.60	3.92	9.70	2.57
Anglo Americans	9.81	2.46	11.78	3.82	9.83	4.35	9.81	3.88

In Table 2 may be found the means and standard deviations for Attitude toward Therapist Factor (1) scores. The three-way analysis of variance for Attitude toward Therapist scores on all 187 subjects revealed a significant Therapist Ethnicity x Therapist Expertise interaction ($F = 4.33$, $df = 1, 179$, $p < .05$). Inspection of Figure 2 shows that the Anglo professional ($\bar{x} = 9.77$) and the Chicano nonprofessional ($\bar{x} = 9.75$)

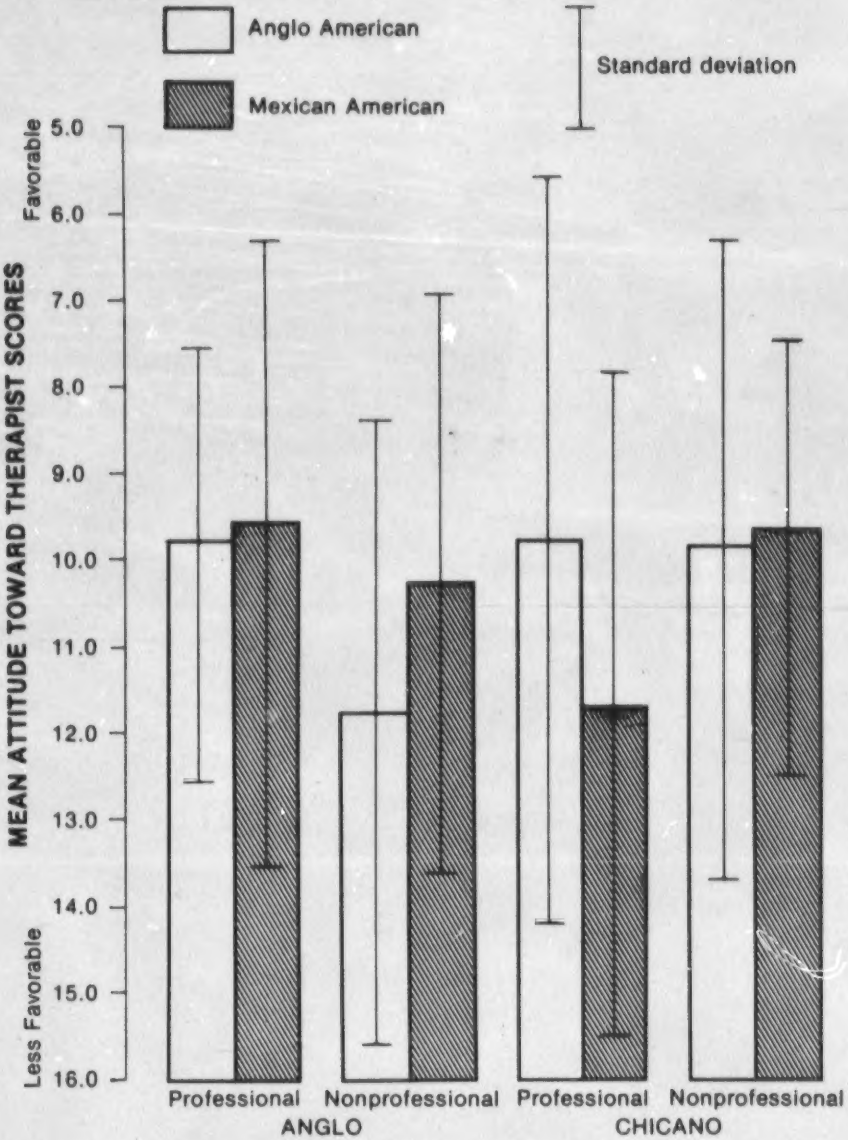

Figure 2. Means and Standard Deviations for Attitude toward Therapist Factor (1) ratings by 94 Mexican American (Chicano) students and 93 Anglo American (Anglo) students. Minimum score possible: 4; Maximum score possible: 24. The lower the score, the more favorable the attitude. Therapist Ethnicity X Expertise interaction was significant ($p<.05$).

were rated more positively than either the Chicano professional ($\bar{x} = 11.01$) or the Anglo nonprofessional ($\bar{x} = 10.72$).

Analysis of variance for subjects in the Medium Occupational Rank showed no significant differences on the Attitude toward Therapist Factor (1). Here, Mexican Americans and Anglo Americans did not show significant differences in their moderate but positive perceptions of the therapists.

Analysis of variance for all subjects revealed significant group differences on the item Similarity to Therapist Attitude. On this Attitude item, Mexican Americans saw themselves as slightly more similar to all of the therapists than did Anglo Americans, who tended to see themselves as not similar to the therapists. Mexican Americans saw themselves overall as slightly more similar to both Anglo and Chicano therapists than did Anglo Americans. In this regard, they showed a more positive attitude toward Anglo therapists than did Anglo Americans for Chicano therapists.

Both Mexican Americans and Anglo Americans saw themselves a little more like the Anglo therapists than like the Chicano therapists. Mexican Americans also saw themselves as slightly more similar to the nonprofessional than to the professional, who was seen as slightly more dissimilar. Seen as least similar by the Mexican Americans was the Chicano professional. Anglo Americans saw themselves as somewhat dissimilar to both professional and nonprofessional therapists.

Analysis of variance for the Similarity to Therapist item scores indicated that there was a significant main group effect ($F = 5.07$, $df = 1, 179$, $p < .05$), a significant Therapist Ethnicity effect ($F = 3.80$, $df = 1, 179$, $p < .05$), and a significant Subject Ethnicity x Therapist Expertise interaction ($F = 5.37$, $df = 1, 179$, $p < .05$).

Significant group differences on the Similarity to Therapist attitude item appeared among subjects in the Medium Occupational Rank. As in the findings for the total sample, Mexican Americans saw themselves as slightly more similar to the therapists than did the Anglo Americans.

Attitude toward Psychotherapy

As indicated by the analysis of variance on the Utility of Psychotherapy item, Mexican Americans showed a significantly more favorable attitude toward the usefulness of therapy than Anglo Americans. Analysis of variance for all subjects on the Utility of Psychotherapy item showed that Mexican Americans thought more that psychotherapy would be "helpful for anyone who is emotionally disturbed" than did Anglo Americans.

On the Utility of Psychotherapy item, subjects in both ethnic groups who had been in the Anglo Therapist conditions significantly saw therapy as more useful than did subjects who had been in the Chicano Therapist conditions. In addition, Mexican Americans in the Chicano Professional condition reflected a less positive attitude toward therapy than did Mexican Americans in the other therapist conditions. On the other hand, Anglo Americans in the Chicano Nonprofessional condition reflected a less positive attitude toward therapy than did Anglo Americans in the other therapist conditions.

Table 3

Means and Standard Deviation of Errors for Utility of Psychotherapy item ratings by 94 Mexican American (Chicano) students and 93 Anglo American (Anglo) students. Each student was in one of four Therapist Conditions only. Minimum score possible: 1; Maximum score possible: 6. The lower the score, the more favorable toward therapy utility was the rating.

	Therapist Condition							
	Anglo Professional		Anglo Non-professional		Chicano Professional		Chicano Non-professional	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Mexican Americans	2.04	1.14	2.08	1.38	3.05	1.76	2.30	1.33
Anglo Americans	3.14	1.49	2.50	.93	3.15	1.95	3.50	1.85

In Table 3 may be found the means and standard deviations for all subjects on the Utility of Psychotherapy attitude item. Analysis of variance revealed a significant main group effect ($F = 9.99$, $df = 1, 176$, $p < .01$), a significant main Therapist Ethnicity effect ($F = 6.32$, $df = 1, 176$, $p < .01$), and a significant Subject Ethnicity x Therapist Ethnicity x Therapist Expertise interaction ($F = 3.95$, $df = 1, 176$, $p < .05$). Figure 3 shows these group differences on the Utility of Psychotherapy item scores.

Results for subjects in the Medium Occupational Rank on their attitudes toward the utility of psychotherapy were similar to those noted above for all 187 subjects.

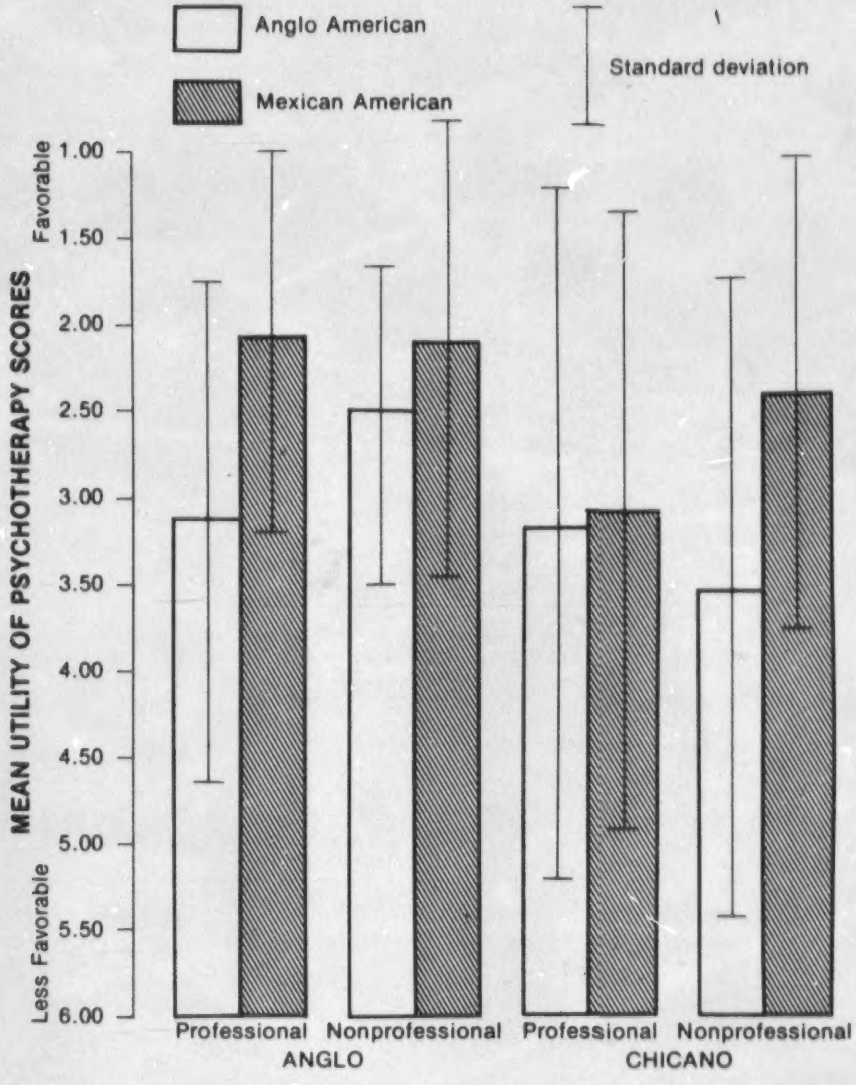

Figure 3. Means and Standard Deviations for Utility of Psychotherapy item ratings by 94 Mexican American (Chicano) students and 93 Anglo American (Anglo) students. Minimum score possible: 1; Maximum score possible: 6. The lower the score the more favorable to therapy utility. Overall group differences between Anglo Americans and Mexican Americans were highly significant ($p<.01$). Therapist Ethnicity effect was also significant ($p<.01$).

Self-Esteem Measure

Scores on the Bentler (1972) Psychological Scale 24 were examined in a three-way analysis of variance for Anglo American and Mexican American subjects both in the Medium socioeconomic group and across all subjects. No significant differences were found. On this scale a maximum score of 26 is possible and indicates high positive self-esteem. Across all 187 subjects, both Chicanos ($\bar{x} = 19.42$) and Anglos ($\bar{x} = 18.53$) scored in the direction of positive self-esteem.

Discussion

The results of this study indicated that Mexican Americans differed significantly from Anglo Americans in the degree of their self-disclosures to the therapists of different ethnicity and professional level. While both ethnic groups showed some positive willingness to disclose to therapists, Mexican Americans showed significantly less willingness to disclose than did Anglo Americans. The finding that Mexican Americans showed less self-disclosure than Anglo Americans to both Chicano and Anglo therapists was in support of the study's general hypotheses.

In support of another hypothesis, both Anglo Americans and Mexican Americans showed differential preferences to therapists who were of different ethnicity and expertise. Scores by all subjects on the Attitude toward Therapist Factor (1) revealed a significant Therapist Ethnicity x Therapist Expertise interaction effect. This finding indicated that both Mexican Americans and Anglo Americans attributed more skill, understanding, trustworthiness, and attraction to therapists who were identified as either Anglo American professional or as Mexican American nonprofessional. Thus it appears that the experimental conditions of changing the role and ethnic introductions to the matched therapist audiotapes were effective in securing differential responses, even though the responses were not always in the predicted direction.

A prediction that professionals of ethnicity similar to the subjects would receive the strongest positive response from the two ethnic groups held only for the Anglo Americans. On the other hand, Mexican Americans had been predicted to show favorable response to the Anglo American professional, and this prediction was supported.

The finding that the Chicano nonprofessional elicited from both ethnic groups a positive response similar to that elicited by the Anglo professional was unexpected. Why the Chicano nonprofessional was significantly seen in a more positive way by both Chicanos and Anglos than either the Anglo nonprofessional or the Chicano professional is

difficult to interpret. However, this finding provides some support for the findings by Brabham and Thoreson (1973) that college students preferred more to disclose to a physically disabled therapist than to an able-bodied therapist. Brabham and Thoreson suggested that a therapist who is seen as "handicapped," whether physically or by life experiences, may evoke greater credibility and trust. This suggestion was only speculative, however, and relied on no substantial evidence. In a study by Acosta (1974), it was found that even though white college students attributed the most negative attitudes to a therapist introduced as a Chicano nonprofessional, they still showed more self-disclosure to him than to a therapist introduced as an Anglo nonprofessional or as a Chicano professional.

The Chicano professional was regarded by both ethnic groups less favorably than was the Chicano nonprofessional. One possible interpretation may be that the therapist introduced as a Chicano professional was just not seen by the subjects as credible, as truly qualified. In line with the already noted lack of Mexican Americans in any professional field, such a minority professional may not have achieved public credibility. For example, a recent survey by Ruiz (1971) indicated that there were only twenty-eight Mexican American clinical psychologists and twenty Mexican American psychiatrists in the United States. In these circumstances, it is easy to understand that members of a Mexican American's own group may particularly lack confidence in him. Thus, in spite of an apparently strong ethnic identification, the Chicano students did not show very favorable attitudes toward the Chicano professional.

Another possibility for the disenchantment with the Chicano professional by both ethnic groups may have been the therapist's slight Spanish accent. Even though the therapist who was introduced as a Chicano nonprofessional also received the introduction of a Chicano professional, it may be that the accented speech was seen as more incompatible with the higher expert introduction given for the Chicano professional. A future study could investigate the effects of manipulating ethnic and expertise identifications with a therapist who speaks fluent English with no Spanish accent. Of particular interest would be the effect of such a presentation on the Chicano responses to the Chicano professional.

The data on perceived similarity to the therapist indicated some striking differences between the Chicanos and the Anglos, both when matched on Medium socioeconomic level and across all subjects. Chicanos significantly saw themselves as more like the therapists,

whether professional or nonprofessional, than did the Anglos, who tended not to see themselves as similar to the therapists. On the measure of Similarity to Therapist, Chicanos thus demonstrated a more positive attitude toward the therapists than did Anglos. Moreover, on the Similarity to Therapist item, Chicanos saw themselves as qualitatively more similar to the nonprofessionals than to the professionals. Several authors (e.g., Padilla, 1971b; Sue, 1973) argue that indigenous and nonindigenous nonprofessionals may be particularly effective for therapeutic interventions with minority members.

The findings on perceived similarity imply that the Mexican American may be more amenable to therapeutic intervention by both professionals and nonprofessionals than has been thought. The fact that Mexican Americans proportionately are not using therapeutic services calls for a more intense examination of how this service can become more available to the Mexican American. What factors, for example, need to be changed in order for practicing therapists to become more accessible to the Mexican American?

The finding that Chicanos showed less self-disclosure than Anglos, within the imagined context of a first-time interview, suggests the possibility that Chicanos may hold a more reserved attitude about disclosing to a stranger, in this case, a therapist. This implication needs to be investigated in future research. The implication for services from the results on self-disclosure is that even though Chicanos may hold a positive view of therapy, they may also be more discriminative than Anglos and thus require more personal and actual evidence of the therapist's ability to understand and to help.

There are no studies that provide cross-cultural information comparing Mexican Americans with other ethnic groups in their reactions to a first contact with a therapist. Do Mexican Americans, for example, terminate therapy at rates greater than those for Anglos or for other minority groups? If so, are such termination rates due mainly to the feeling that the therapist does not understand or cannot help? Indeed, a limitation to the present study is that actual therapist-client or therapist-student interactions were not examined. More definitive answers to the disclosure styles of Chicanos may be gained in empirical investigations of actual interactions.

This study has indicated that Mexican Americans are, in general, willing to make disclosures to therapists regardless of whether the therapist is professional or nonprofessional, Anglo or Chicano. This pattern held across factors of the subject's sex and socioeconomic class. These findings are certainly in contrast to the generally held assumption

that Mexican Americans, particularly males, are not very willing to talk about personal matters. In this study, the young Chicanos showed a moderately positive willingness to talk to the therapist about such personal areas as sex, work, body, and personal problems. Even though the self-disclosure scores were statistically lower for the Chicano subjects than for the Anglos, the finding that these scores tended to show a positive willingness to talk to the therapist is important.

More specific information is needed for a better understanding of the general self-disclosure styles of Mexican Americans. For example, techniques such as those used by Jourard (1971), which investigate self-disclosures in dyadic interactions between strangers or in questionnaire responses to significant others, could be applied to Mexican American populations.

In the study reported here, Mexican Americans significantly saw psychotherapy more as helpful for "anyone who is emotionally disturbed" than did Anglo Americans. How the subjects interpreted "emotionally disturbed" is difficult to ascertain. It would be important to determine whether the favorable Mexican American response on this item was in reference only to people who are severely disturbed or whether some kind of continuum of emotional states was reflected. In future work, it would be important to discover whether the Anglo American group, or any comparison group, holds widely varying definitions of the term "emotionally disturbed."

Interestingly, Mexican Americans in the Anglo Therapist conditions saw psychotherapy as more useful than did Mexican Americans in the Chicano Therapist conditions. It appears that Mexican Americans, at least at a junior college level, attribute more skills to therapists who are identified as Anglo American than to those who are identified as Mexican American. This pattern suggests that Mexican Americans, who have very few expert role models to identify with, may in fact be suspicious of the competence of an expert who is of similar ethnic identity. If this interpretation is accurate, a grave situation exists which must be changed. This finding underscores the patent need for more Chicano professionals and, in this case, for more Chicano mental health professionals.

It seems plausible that increasing the number of Mexican American professionals will make their role less of a novelty among Mexican Americans, and their function as qualified professionals will become more respected, at least among those Mexican Americans who are young and speak fluent English. It remains for future research to discover how Mexican Americans who are comfortable only in Spanish

would respond to professional therapists who are either Mexican American or Anglo American, and who are either able or not able to speak Spanish. Also, it may be that Mexican American therapists are viewed with respect by community residents. These findings may be due to the fact that subjects in this study are junior college students who have become accustomed to viewing Anglo Americans as teachers and as authority figures, in the absence of Mexican American professionals.

In order to expedite clinical services for some Mexican Americans, it may become necessary to employ translators. However, many nuances of attitude and feeling may be lost or distorted in the process. Important information necessary to accurate diagnosis may also be lost. There is the additional complication of working with two mental health interviewers rather than just one. The effect of the triad may be quite different from that of the dyad.

Interestingly, the ethnic differences found in this study on attitudes toward the utility of psychotherapy are in marked contrast to those found by Wolkon and others (1973) with black and white college students. Wolkon found that blacks preferred black therapists, and that lower-class blacks viewed therapy more negatively than did middle-class blacks or whites. The present findings on the Utility of Psychotherapy attitude item indicated that Chicanos held significantly more positive views toward therapy than did Anglos. No socioeconomic differences in the attitude toward the utility of therapy were found among either the Chicanos or the Anglos. The implication from the contrast of these with Wolkon's findings is that Chicanos may indeed have views of psychotherapy which differ markedly from those held by whites and/or other minorities.

Recommendations

Mexican American psychologists (Padilla and Ruiz, 1973), and a task force of sociologists and interdisciplinary professionals (Alvarez et al., 1974), have recently argued for increased research support and increased efforts to improve mental health services for the "Spanish speaking/Spanish surnamed" population. The recommendations of these behavioral scientists are timely. Their recommendations range widely from a call for more basic research with the Spanish speaking population in such specific areas as psychological assessment to mandates for government to augment funding of bilingual and bicultural mental health centers and interdisciplinary research centers.

Several recommendations for future research with the Mexican American in the area of client-therapist interactions have already been

made in this discussion. Additional recommendations for research and public policy, based on the findings in this study, are presented below.

The major finding that the Chicano professional was seen least positively by both Mexican Americans and Anglo Americans in the study suggests that Mexican Americans in particular did not have much credence in this therapist. It may be that the Mexican Americans, in spite of an apparently strong self-identification as Mexican Americans, had incorporated the dominant society's negative stereotype of the Mexican American—even for one who is successful. More research on the effects of negative stereotypes on the Mexican American's perceptions of his own people is needed. In particular, efforts to correct an evidently adverse situation must be made at both local and governmental levels. Such efforts could include, for example: (1) greater numbers of appointments to high-level national, state, and city offices for qualified Mexican Americans, to allow for more visibility of successful role models; and (2) more favorable publicity for the Mexican American.

It is clear that Mexican Americans are grossly underrepresented in the mental health profession. Efforts to recruit college students into graduate programs in these professions have begun but must be greatly accelerated. The recent minority fellowships sponsored by the National Institute of Mental Health for graduate students in the professions of psychology, psychiatry, and psychiatric social work are a step in the right direction. How much impetus this limited fellowship program will have for Chicano students is not yet known. Increased fellowship funding for Chicano graduate students is certainly warranted.

The finding that Mexican American junior college students held a more positive view of the utility of psychotherapy than did Anglo Americans calls for a greater examination of their actual participation in psychotherapy and related psychological services. In addition, evaluation of how psychotherapy is perceived by different subgroups of Mexican Americans needs to be done. Basic information on the proportion of participation in mental health services by different age groups of Mexican Americans is also sorely needed. As already noted (Padilla, 1971a), basic epidemiological surveys of a national scope are definitely needed to ascertain the incidence and prevalence of severe and moderate psychological disorders. Information is needed on the course and outcome of those who seek psychological help and those who do not.

Public policy needs to be stimulated to encourage mental health clinics that service a community with a moderate proportion of Mexican

American residents to evaluate their services to the Mexican American. In order to upgrade clinical services, Mexican American professionals should be recruited to those areas that have the highest density of Mexican Americans. Specific evaluation site visits should be made by governmental funding sources to all clinics which have a moderate percentage of Mexican Americans in their catchment area. The purpose of these visits would be to determine the quality of services being provided. Mental health clinics and centers should be providing the same quality services to the Spanish speaking as to any other population subgroup. Clinics which are not meeting the needs of the Spanish speaking should at least be provided with consultation aimed at teaching their staff more about the cultural and psychological perspectives of the Mexican American.

Through federal, state, or county funding, Mexican American mental health professionals should be encouraged and given the opportunity to visit mental health clinics that provide services to the Spanish speaking without the help of bilingual and bicultural professional staff. The consultant on these visits could lead workshops or seminars which focus on the Mexican American's perspectives and could provide suggestions for improved clinical services. Since the current ranks of the Mexican Americans in the mental health professions are relatively so small, such a countywide, statewide, or national program would serve to maximize the impact of these Chicano professionals.

Nonprofessionals have been seen as one answer to help meet the mental health needs of minorities. However, the effectiveness of the minority nonprofessional needs rigorous investigation. As Morales (1971) has cautioned, quality treatment could be sacrificed if mental health centers rely only on one or a few nonprofessionals to provide psychiatric services to the Mexican American community. Even though Chicano students reacted positively to the Chicano nonprofessional in the study here reported, it has not been convincingly demonstrated how effective Chicano nonprofessionals can be in dealing with different problems Nor has the necessary degree of training for effective intervention by a nonprofessional been determined. Indeed, the problem of type and amount of training is one which persists even in the training of the professional psychotherapist.

The major finding that Mexican Americans are willing to disclose in general to psychotherapists, but significantly less so than Anglo Americans, calls for increased research on the self-disclosure styles of Mexican Americans. In addition, a statewide and national funding priority should be given to encouraging research on the most effective

treatment modalities for the Mexican American. It should be noted that Mexican Americans are a heterogeneous population; this heterogeneity will probably have interactive effects with any specific treatment modality. The interactive effects of the therapist's characteristics, as found in this study, must also be considered in any research done with Mexican Americans.

There are no studies which attempt to evaluate the effects of differential treatment approaches with Mexican Americans. Would behavior therapy be more effective with the Spanish speaking than more traditional psychodynamic or verbal therapy? Lorion (1974) has asked a similar question in considering the efficacy of psychiatric treatment for patients in the lower socioeconomic classes. As indicated earlier, the poor typically receive more chemotherapy than psychotherapy. While this approach may be adequate for some patients, it is most probably not for most. The fields of psychiatry and psychology continue to see tremendous growth in the number of treatment approaches being implemented to help people in psychological distress. The effectiveness of these methods needs to be tested empirically for their utility with the Mexican American and other Spanish surnamed Americans.

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